CONNECT
speech language & swallowing services

SPEECH-LANGUAGE PATHOLOGY REFERRAL FORM

Patient's Name: _____ Gender: ____Date of Birth: _____

Patient's Phone: _____ Alternate contact: _____

Reason for Referral:

- ☐ Speech sound/articulation difficulties
- ☐ Fluency/stuttering
- ☐ Language delay/difficulty
- ☐ Social communication difficulty
- ☐ Literacy difficulty
- ☐ Developmental delay/difficulty
- ☐ Swallowing difficulty
- ☐ Cognitive changes/impairment
- ☐ Neurological incident/condition
- ☐ Degenerative condition
- ☐ Professional communication skills
- ☐ English accent enhancement
- ☐ Other: _____

Comments:

_____

_____

Referrer: _____

Phone: _____ Fax: _____

_____ _____

Date of referral Referrer signature

Note: Please inform patient/client that this is a private practice. Therefore, services fees are **not OHIP covered.** SLP service fees may be covered by additional sources, such as the individual's Employee Health Benefits insurance, BlueCross for Veterans, charities or government programs (e.g. Jordan's Principle for First Nations children). Expenses may also be considered for income tax purposes. Please enquire for more details.

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