connect KIDS
SPEECH THERAPY

SPEECH-LANGUAGE PATHOLOGY
PEDIATRIC REFERRAL FORM

PEDIATRIC REFERRALS FOR CHILDREN AGED 0-12.

FOR REFERRALS AGED 13+ PLEASE INDICATE AGE & EMAIL INFO@CONNECTSPEECH.CA

Client:

Name: _____ Sex: ____ DOB (D/M/Y):_____Age:_____

Parent/Guardian: _____ Phone: _____

Alternate contact: _____

Reason for Referral:

_ Speech sound/articulation difficulties

_ Fluency/stuttering

_ Language delay/difficulty

_Social communication difficulty

_ Voice concerns

_ Literacy difficulty: reading writing

_ Learning disorder

_ Developmental or intellectual delay

_ Concussion

_ Other neurological incident/condition

_____

_ ASD _ Down Syndrome

_ ADHD _ Cerebral Palsy

_ Other: _____

Comments:

_____

Referrer:

Name: _____Title/Profession: _____

Phone: _____ Stamp:

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, charities or government programs (e.g. Ontario Autism Program, Jordan's Principle for First Nations children). Expenses may be considered for income tax purposes. Enquire for more details.*