SPEECH PATHOLOGY
PAEDIATRIC REFERRAL FORM

Ballarat Health Services- Queen Elizabeth Centre

Referral Date: ___________

CONTACT INFORMATION

CHILD'S NAME: ______________________________ Male / Female

ADDRESS: ______________________________

______________________________ Postcode:__________

COUNTRY OF BIRTH: ______________ DATE OF BIRTH: ______________

Is the child of Aboriginal or Torres Straight Islander origin? Yes ☐ No ☐

MEDICARE NUMBER: ____________________ Child's Number on card:__________

PARENT/CARERS' NAMES: ______________________________

PHONE: HOME:__________ WORK: __________ MOBILE: __________

ADDRESS (If not same as child's): ______________________________

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RELATIONSHIP TO CHILD: ______________

Primary language spoken at home: __________ Interpreter required: Yes ☐ No ☐

REFERRER'S Name: ______________ Position: ______________

Agency Name: ______________________________

Address: ______________________________ Postcode: __________

Phone No: ______________ Mobile:______________

Email Address: ______________________________

This child is in: Childcare ☐ 3 y.o. Kinder ☐ 4 y.o. Kinder ☐ - 'Early Start' Yes/No **None ☐**

Will this child attend school next year? Yes ☐ No ☐ Unsure ☐

PROFESSIONALS INVOLVED:
Has your child been seen by anyone in relation to your concerns about their development?
GP name & contact details is a mandatory field.
i.e. Paediatrician, Maternal & Child Health Nurse, Medical Specialist, Therapist etc.

GP:__________ Practice:____________________ Ph. No__________

Name	**Profession**	**Phone No**	**Report Attached**	
____________	____________	____________	Yes ☐	No ☐
____________	____________	____________	Yes ☐	No ☐
____________	____________	____________	Yes ☐	No ☐

REFERRAL INFORMATION

REASON FOR REFERRAL: (Tick all relevant areas)

- ☐ **Speech** – A child's ability to produce sounds and to use sounds in words.
- ☐ **Expressive Language (Production) -** This includes vocabulary, combining words in phrases and sentences and use of grammatical structures.
- ☐ **Receptive Language (Understanding)** - This includes following directions, understanding concepts, listening skills.
- ☐ **Stutter –** Repetitions of sound, syllables or words or other forms of stuttering.
- ☐ **Voice –** Unusual voice quality present.
- ☐ **Social Skills –** For example: turn taking, eye contact, joint attention, topic initiation/maintenance and gesture and body language.

COMMENTS/ EXAMPLES ABOUT CONCERNS:______________________________________

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ADDITIONAL INFORMATION:
Concerns with other areas of development (Please circle relevant area/s):
Gross Motor / Fine Motor / Sensory / Cognition / Play / Self Care / Behaviour / Hearing / Vision

Please describe (examples, diagnosis): ______________________________

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Important: If a child has a diagnosis (such as ASD/Global Developmental Delay) or needs in multiple areas identified above, please submit a **referral to ECEI/NDIS** first. Please only refer to Ballarat Health Services speech pathology (which is a Community Health service) if the child is not eligible for ECEI/NDIS.

RELEVANT FAMILY INFORMATION:
E.g. Family history of developmental problems, stress factors, illness

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PARENTAL / GUARDIAN CONSENT:

I consent to a referral being made to Speech Pathology, Ballarat Health Services (BHS).
I give permission for BHS to make contact with the referrer and professionals listed on this form to discuss the reasons for referral.

Signature: ____________________Name: ____________________Date: _______

Please return completed form to:

Ballarat Health Services- Queen Elizabeth Centre,
Central Intake
P.O. Box 577, BALLARAT, VIC, 3353.
Telephone: (03) 53206690 or 53206869 Fax: (03) 53203893
Email: CentralIntakeTriage@bhs.org.au