Emilia Villani

Referral Form

Speech Pathology Australia
Certified Practising Speech Pathologist

CHILD'S DETAILS

Child's Full Name _____ Date of Birth _____

Gender _____ Home Address _____

PARENT/GUARDIAN DETAILS

Caregiver Full Name _____ Phone Number _____

Address _____

Occupation _____

Email _____

LANGUAGES SPOKEN OTHER THAN ENGLISH

Language spoken in the home environment _____

Language spoken by caregiver _____

Language spoken by child _____

If a language other than English is spoken, are there concerns about your child's development in that language? _____

REASON FOR REFERRAL

What is your reason for referring your child?

_____

_____

_____

Please tick the area/s that are most relevant in describing the reasons for concern for your child (you may select more than one).

☐ Inability to correctly produce speech sounds in words (e.g., "tat" instead of "cat")

Emilia Villani | Speech Pathologist | B.SP., CPSP | ABN 38 565 815 425
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- ☐ Requires your support following directions and/or daily routines
- ☐ Difficulty responding to spoken language or answering simple questions
- ☐ Difficulty expressing wants, needs or opinions (verbally or nonverbally)
- ☐ Limited vocabulary and talking
- ☐ Does not seem to be communicating as well as others of the same age
- ☐ Demonstrating frustrated behaviours due to difficulty communicating or understanding
- ☐ Self-help skills (e.g., dressing, toileting, brushing teeth)
- ☐ Difficulty engaging in play

Provide any other areas of concern or comments you would like to add

_____

_____

_____

What does your child enjoy? What are his/her strengths?

_____

_____

_____

What would you like to gain from receiving this service?

_____

_____

_____

What are your main priorities and goals?

_____

_____

_____

Please tick your request/s from this service (you may select more than one)

- ☐ speech pathology assessment
- ☐ assessment report
- ☐ individual therapy
- ☐ consultation of recommendations

EXTERNAL SERVICES

Has your child previously been seen by a Speech Pathologist? No ☐

If yes, specify _____

Has your child accessed any medical or allied health services before? No ☐

If yes, specify _____

Is your child currently on any allied health services waiting list? No ☐

If yes, specify _____

Is there potential that your child will enter the public Education system (Department for Education) at preschool or school in South Australia? No ☐

If yes, specify _____

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DIAGNOSIS

Has your child received a formal diagnosis of any disorder, disability, or syndrome? N/A ☐

If yes, specify _____

If yes, when was the diagnosis given _____

PAYMENT

Please indicate how speech pathology sessions will be paid

Tick For Yes

National Disability Insurance Scheme (NDIS) ☐

If NDIS, is your child's plan: Self-Managed ☐ Plan-Managed ☐

If NDIS plan managed,

Organisation _____ Name _____

Phone Number _____

If you have an NDIS plan, please attach it to this form. This is required prior to your first appointment.

Private Health Care Insurance (under the extras cover) ☐

If yes, specify which Insurer _____

Chronic Disease Management Plan (CDMP) ☐

Helping Children with Autism Plan (HCAP) ☐

Please attach the referral form and plan from the General Practioner or Paediatrician for CDMP and HCAP rebates. These forms are required prior to your first appointment.

Private (I am paying the out-of-pocket fee, with my own money) ☐