



## Speech Pathologists

Adult & Paediatric

Certified Practicing

Ph: 02 4945 1819 Fax: 02 4913 5328

ABN: 29110852429

Address: 14 High Street, Belmont, NSW, 2280

## Referral Form

**Please complete the entire form to prevent any delays in processing**

<b>Urgency of referral:</b>	Immediate Response* <input type="checkbox"/>	Within _____ weeks <input type="checkbox"/>	As time permits <input type="checkbox"/>
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\* Immediate response requests will be triaged by the Director and are not guaranteed. We may suggest another service or to seek medical treatment.

### CLIENT INFORMATION:

Name:			
Date of Birth:		Gender:	
Address:			
Client Email:			
Client Phone Number:			
Descent:			
Diagnosis: <b>(Compulsory Information required)</b>			
Does the client live with or have anyone else present in the home? (NDIS only)	Support Worker		
	Family / friend		
	Lives alone		
GP Contact Details:	Name:		
	Surgery Name:		
	Address:		
	Phone:		
Medical Specialist Details:	Name:		
	Surgery Name:		
	Address:		
	Phone:		



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### CONTACT DETAILS FOR: Person Responsible / Next of Kin / Parents (Compulsory Information required)

Name:			
Relationship:			
Address:			
Phone:			
Email:			
Preferred method of document correspondence:	Post	Email	DocuSign
Is this person responsible for signing the Service Agreement?	Yes	No	

### REFERRER DETAILS: (if applicable) – (where the referral has come from)

Name:			
Company / Address:			
Phone / Mobile:			
Email:			

### FUNDING TYPE:

NDIS	<input type="checkbox"/>	iCARE	<input type="checkbox"/>	Aged Care	<input type="checkbox"/>	Other:
DVA	<input type="checkbox"/>	Private Health Fund	<input type="checkbox"/>	Medicare	<input type="checkbox"/>	
Medicare number:						
Private Health Insurance:						
Member number:						



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**NDIS PARTICIPANTS ONLY**

**COORDINATOR OF SUPPORTS:**

Name:

Company Name:

Phone / Mobile:

Email:

NDIS Plan Details:

NDIS Number

NDIS Plan start date

NDIS Plan end date

**NDIS PLAN DETAILS:**

How is your plan managed?

AGENCY MANAGED  
(NDIS Managed)

PLAN MANAGED

SELF MANAGED

Company Name of Plan Manager?

Funding Amount or No. of hours for this plan:

\$

hours

Where is the funding coming from:

CB Daily Living

Core Supports

**NDIS GOALS: (Compulsory information required)**



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About The Person						
Who is the best contact regarding making or changing appointments?						
Accommodation Type: (please tick)						
Private (family or independently)	<input type="checkbox"/>	Group Home (SIL)	<input type="checkbox"/>	Other	<input type="text"/>	
Who else lives with the person?						
Is there a family court order in place? (Please provide a copy)						
Who has parental responsibility?						
Is there stress in the family household?						
Is there anything that we need to know about the family / household?						
Is the house safe to visit?						
Are there any other issues we need to know about?						
Medications:						
How is the persons self-esteem?	<input type="checkbox"/>	Low	<input type="checkbox"/>	Normal	<input type="checkbox"/>	High
Clients' Interests:						



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Daily Routine	
Does the person attend a day program or school?	
Where?	
Address:	
Contact Person:	
Phone/Mobile:	
Email:	
REASON FOR REFERRAL: (Please tick AND write down any other diagnosis)	
Speech Pathologists work in:	
Communication impairment (difficulty understanding and using language to express ideas / convey messages)	
Voice impairment (voice doesn't sound like it is supposed to)	
Unclear speech, stuttering	
Fluency issues	
Learning difficulties	
Auditory memory	
Auditory processing difficulty	
Literacy / dyslexia, written expression	
Swallowing impairment (choking / chest infections / sensation of food getting stuck)	
Saliva management	
Alternative means to communicate such as pictures / apps / ipads / voice output systems	
Other information that might be useful:	



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<b>Condition / Diagnosis</b> (Please tick AND write down any other diagnosis)	
Intellectual Disability	
Mental health issues	
Behaviours of concern	
Physical disability / limited mobility	
Autism spectrum disorder	
Verbal communicator	
Non – verbal	
Learning difficulties	
Difficulty with comprehending language / following instructions	
Difficulty expressing, using language to communicate	
Difficult to understand	
Difficulty with memory / retaining information	
Difficulty with social language / socially communicating with others	
Swallowing difficulty	
Other Diagnosis:	

<b>CURRENT DIET / SWALLOWING</b>		<b>(PLEASE INDICATE WHICH LEVEL)</b>	
What IDDSI level is the client on for food?	7	Regular	
	6	Soft & Bite-sized	
	5	Minced & Moist	
	4	Pureed	
	3	Liquidised	
What IDDSI level is the client on for drinks?	4	Extremely Thick	
	3	Moderately Thick	
	2	Mildly Thick	
	1	Slightly Thick	
	0	Thin / Normal	
Any Food Allergies?			
Have there been any chest infections?			
Have there been any choking incidents?			



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OTHER ALLIED HEALTH PROFESSIONALS INVOLVED:									
<b>Dietitian</b>	Name:								
	Company Name:								
	Mobile:								
	Email:								
<b>Psychologist</b>	Name:								
	Company Name:								
	Mobile:								
	Email:								
<b>Occupational Therapist</b>	Name:								
	Company Name:								
	Mobile:								
	Email:								
<b>Physiotherapist</b>	Name:								
	Company Name:								
	Mobile:								
	Email:								
Type of Speech Pathology service required?	Communication Assessment and Report								
	Swallowing Assessment (including Mealtime Management Plan & Report)								
	Saliva Management (including Enteral Feeding Plan & Report)								
	Ongoing Speech Therapy								
	Weekly			Fortnightly			Other:		
	Behaviour Assistance								
	Voice								
	Memory / Cognitive								
Appointment Venue	Clinic			Home Visit			Online / Zoom		
	School Visit			School Attending:					
Appointment Time	Preferred day				Preferred time				

Please return this Referral to Communicate Connect Speech Pathology via email: [reception@ccspeech.com.au](mailto:reception@ccspeech.com.au) or post to 14 High Street, Belmont NSW 2280