

## CLIENT INFORMATION & REFERRAL DETAILS

A parent/guardian must sign all referrals before being returned.  
Please complete ALL sections & send to:  
Bellfield Speech Pathology PO Box 1075 Warragul 3820.

### 1. PERSONAL INFORMATION OF CLIENT

Name: .....	Date of Birth: .....	Sex: M/F Age: .....
Address: .....		
Phone No: .....	Nationality: .....	
Languages other than English spoken in home: .....		

### 2. FAMILY DETAILS

Name	Home Phone	Business Phone	Occupation
Mother: .....			
Father: .....			
Carers: .....			

#### Child lives with:

- |                                               |                                           |                                         |
|-----------------------------------------------|-------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Birth Parents        | <input type="checkbox"/> Adoptive Parents | <input type="checkbox"/> Foster Parents |
| <input type="checkbox"/> Parent & Step Parent | <input type="checkbox"/> One Parent       | <input type="checkbox"/> Other .....    |

Siblings Name	Age	Sex	Grade	Speech & Language Difficulties?
.....				
.....				
.....				

### 3. SCHOOL DETAILS

Year	School/Kinder	Phone	Year Level	Teacher	Aide	Principal
2008:	.....					
2009:	.....					

Has your child ever repeated a grade?    Y/N

What are your child's strengths or best subjects? .....

Is your child having difficulty with any subject? .....

Is your child receiving help in any subject? .....

### 4. WHO REFERRED YOU

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**5. INFORMATION ABOUT THE REASON FOR REFERRAL**

**Do you feel your child has a speech, language or literacy difficulty?**      **Y/N**

*Please describe what your concerns are about your child's development:*

**Disordered speech/articulation** e.g. difficult to understand due to omission or substitution of sounds

**Disordered language**

**Understanding of language** e.g. gives inappropriate, incomplete or no response to questions

**Use of language** e.g. has difficulty using/forming sentences to express ideas

**Stuttering** e.g. frequent repetition of sounds, words or phrases, get "stuck" on words

**Voice disorder** e.g. hoarse, nasal or monotonous voice quality, inappropriate volume or pitch

**Literacy** e.g. identifying sounds in words or organizing sentences on paper, spelling or reading difficulty

**Feeding & Swallowing** e.g. chokes on food or liquid, taste or texture aversion, constantly put object in their mouth, drools excessively

*Please describe your concerns and reason for referral:*

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**6. DEVELOPMENTAL HISTORY**

*Please comment on pregnancy and birth:* -----

*Approximately when were these milestones achieved:*

Crawling -----      Walking -----

Toilet Trained -----      Teethed -----

Feeding -----      Sat alone -----

*Approximately when were these speech and language milestones achieved:*

Babbled -----      Put 2 or3 words together -----

Said first words -----      Short sentences -----

**7. SOCIAL/BEHAVIOURAL DEVELOPMENT**

cooperative       attentive

willing to try new activities       plays alone for reasonable length of time

separation difficulties       easily frustrated/impulsive

stubborn       restless

poor eye contact       easily distracted/short attention

destructive/aggressive       withdrawn

*Please comment on interactions with family, siblings and peers:* -----

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**8. FAMILY HISTORY**

*Is there a family history of speech, language or learning difficulties?*      **Y/N**

*Please describe:* -----

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**9. HEARING**

Has hearing been tested? Y/N  
If yes, please indicate by whom, when and the results: \_\_\_\_\_  
\_\_\_\_\_

**10. VISION**

Have eyes been tested? Y/N  
If yes, please indicate by whom, when and the results: \_\_\_\_\_  
\_\_\_\_\_

**11. MEDICAL HISTORY**

Family GP and phone number: \_\_\_\_\_  
Operations/Illnesses/Accidents: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Any known Conditions: \_\_\_\_\_  
\_\_\_\_\_

**12. OTHER AGENCIES/SERVICE PROVIDERS**

Has or is your child receiving any other evaluation or therapy by an occupational therapist, physiotherapist, psychologist/ counselor, audiologist, optometrist or paediatrician? Y/N  
If yes, please describe who, when and the results: \_\_\_\_\_  
\_\_\_\_\_

**13. PREVIOUS SPEECH PATHOLOGY**

Has your child ever had a speech pathology assessment or screening? Y/N  
If yes where and when? \_\_\_\_\_  
What were you told? \_\_\_\_\_  
\_\_\_\_\_

**14. HEALTH FUND DETAILS**

Name of Fund: \_\_\_\_\_

**15. WHO IS RESPONSIBLE FOR PAYING INVOICES?**

Preferred method of payment:      cash      direct debit      cheque      credit card  
I understand that your terms are 14 days and that outstanding accounts will incur debt collector fees.  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Signature: \_\_\_\_\_

**Parent / Guardian Consents:**

**PRIVACY**

I have been given a copy of Bellfield Speech Pathology's Privacy Policy and had this verbally explained to me in accordance with the National Privacy Principles that are the basis of the Privacy Amendment (Private Sector) Act 2000 and in accordance with Health Records Acts 2001.

I understand Bellfield Speech Pathology will take reasonable steps to prevent the unauthorised disclosure of personal information. The exception to this being when:

- I provide written or verbal consent to do so to a specified person or agency (eg school).
- It is required under compulsion of law or provided in co-operation with a government authority
- It is already publicly available.
- It is disclosed in a manner that does not readily permit identification of information relating to you.

I understand personal information may be shared among the staff of Bellfield for the purposes of ensuring best possible outcomes for my child or myself.

I understand I am able to access personal information collected and held by Bellfield Speech Pathology on verbal or written request.

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

**LIASON WITH OTHERS AND CONSENT FOR PROVISION OF SERVICES**

(a) I have attached copies of previous reports by Speech Pathologists, Psychologists, Audiologist and other relevant professionals. Y/N

(b) Are there any custody issues that we need to be aware of when distributing information?  
Y/N \_\_\_\_\_  
\_\_\_\_\_

(c) We send a copy of the assessment report to your child's G.P. to ensure they have the information needed should you be eligible for an EPC Plan to claim a Medicare rebate. Do you wish for us to do this? Y/N  
**GP Name and phone no:** \_\_\_\_\_

(d) I consent to Bellfield Speech Pathology consulting with the following professionals to ensure optimum therapy outcomes. This includes releasing and obtaining details of assessment results and therapy progress. Consultation with the following people is permitted: (Please List)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(e) I (Parent's name) \_\_\_\_\_ have read the above information and consent to my child (child's name) \_\_\_\_\_ receiving assistance from Bellfield Speech Pathology. Y/N

Parent's signature \_\_\_\_\_ Date: \_\_\_\_\_