

Please complete all sections of form. Incomplete referrals may be returned.

Referral Date (dd/mm/yyyy)		Personal Health Number		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Client's Name (surname, first name)			Date of Birth (dd/mm/yyyy)		Age (CCA)
Address (including postal code)				Postal Code	
Parent/Guardian			Parent/Guardian		
Home Phone		Cell Phone		Work Phone	
Name of School		Language spoken by client <input type="checkbox"/> English <input type="checkbox"/> Other, specify _____		Interpreter Required <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Physician's Name					

Please check all relevant boxes and provide as much detail as possible.

<input type="checkbox"/> Request for Audiology (0 to 19 years) <input type="checkbox"/> Urgent Request for Audiological Assessment <input type="checkbox"/> Suspected hearing loss (not related to middle ear fluid/infection) <input type="checkbox"/> Ear trauma, specify _____ <input type="checkbox"/> Regular Request for Audiological Assessment <input type="checkbox"/> Middle ear concerns <input type="checkbox"/> Pre/Post-surgery audiogram <input type="checkbox"/> Little or no interest in sound/fleeting attention <input type="checkbox"/> No babbling or cooing/stopped babbling or cooing <input type="checkbox"/> Does not turn to interesting sounds or when name is called <input type="checkbox"/> Swim molds <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Request for Speech-Language*(0 to 5 years) <input type="checkbox"/> Difficult to understand <input type="checkbox"/> Difficulty forming sentences <input type="checkbox"/> Stutters/repeats words <input type="checkbox"/> The child appears to not understand language and cannot follow directions. <input type="checkbox"/> Few words for age <input type="checkbox"/> Voice problem (scratchy, raspy or nasal sounding). <input type="checkbox"/> Behaviour (e.g. aggression, tantrums, impulsiveness, difficulty with social skills) <input type="checkbox"/> Concerns for autism or developmental delay <input type="checkbox"/> Other, specify _____ <small>*Services may be provided by The Centre for Child Development, Reach Child and Youth Society, Surrey Early Speech & Language Program or Fraser Health for children living in Delta, Surrey, Langley or White Rock.</small>
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If there are concerns for autism or developmental delay, specify:

Has a sibling been referred for Speech-Language services? No Yes Clinic/Centre Name: _____

REQUIRED: Parent/guardian is aware of this referral and understands it may be forwarded to other service providers.

Signature of parent or referral source: _____

Previous, current, or waitlisted (if known) physicians, specialists, testing, or clinics attended.

<input type="checkbox"/> Autism/Developmental Assessment	<input type="checkbox"/> Ear, Nose and Throat Specialist	<input type="checkbox"/> Pediatrician
<input type="checkbox"/> Infant Development Program	<input type="checkbox"/> Supported Child Development Program	<input type="checkbox"/> Occupational Therapist /Physiotherapist

Referral Source	<input type="checkbox"/> Family Doctor	<input type="checkbox"/> ENT	<input type="checkbox"/> Pediatrician	<input type="checkbox"/> Parent/Guardian
	<input type="checkbox"/> Public Health Nurse	<input type="checkbox"/> Audiologist/S-L Pathologist	<input type="checkbox"/> Other, specify _____	
Name		Phone	Fax	
Address			Postal Code	
Referral Taken By (please print name)		Designation		

Please note that it is the responsibility of the referring source to fax the completed referral form to the numbers indicated below. Depending on the service(s) provided at each clinic, you may have to fax your referral to more than one location. Services are provided based on client/patient's city of residence.

AUDIOLOGY SERVICES			SPEECH-LANGUAGE SERVICES		
CLINIC	FAX	PHONE	CLINIC	FAX	PHONE
Abbotsford	604-864-3410	604-864-3468	Abbotsford	604-864-3410	604-864-3435
Burnaby	604-918-7660	604-918-7663	Burnaby	604-918-7660	604-918-7663
Chilliwack	604-702-4971	604-702-4944	Central Referral Office (provides referral services to Delta, Langley, Surrey, and White Rock)	604-583-5113	604-587-4273
Cloverdale and White Rock	604-574-2091	604-575-6381	Chilliwack	604-702-4971	604-702-4944
Guildford	604-587-4777	604-587-4751	Coquitlam	*Fax all speech-language referrals to the Tri-Cities Children's Services (SHARE): 604-525-3013	
Langley	604-514-8036	604-539-2904	Maple Ridge	604-476-7077	604-476-7070
Maple Ridge and Mission	604-476-7077	604-476-7070	Mission	604-814-5517	604-814-5500
New Westminster, Port Moody, Coquitlam and Port Coquitlam	604-525-3803	604-777-6855 Ext. 526616	New Westminster	604-525-3803	604-777-6855 Ext. 526616
North Delta	604-591-7382	604-507-5404	Port Coquitlam/ Port Moody	604-949-7211	604-949-7213