SPEECH PATHOLOGY
PAEDIATRIC REFERRAL FORM

BallaratHealthServices

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): _____

_____

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: _____

_____

_____

_____

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): _____

_____

_____

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

_____

_____

_____

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