NL Health Services

SPEECH−LANGUAGE PATHOLOGY REFERRAL FORM − ADULT

❑ Corner Brook Community Health Ctr
1 Brookfield Avenue,
Corner Brook, NL,
Telephone: (709) 637−5374
Fax: (709) 784−5374

❑ Rehabilitation Annex
127 Montana Drive
Stephenville, NL
A2N 2T4
Telephone: (709) 643−8690
Fax: (709) 643−3944

❑ P.O. Box 544
3−9 Barhaven Drive
Port aux Basques, NL
A0M 1C0
Telephone: (709) 695−4523
Fax: (709) 695−2845

❑ 20 Farm Road
Deer Lake, NL
A8A 1J3
Phone: (709) 635−7894
Fax :(709) 635−5211

CLIENT INFORMATION: (Please fill in ALL information below)

NAME: _____ **Gender:** _____
(first) (middle) (last)

MCP#: _____ **DOB:** _____
(year) (month) (day)

ADDRESS: _____
(street/post office box) (city/town) (postal code)

NEXT OF KIN: _____ **RELATIONSHIP:** _____

TELEPHONE #: (home) _____ (work) _____

REFERRAL INFORMATION: * ☑ Check the reason for referral

_____ Articulation (Pronunciation)
_____ Stuttering
_____ Stroke / Head Injury
_____ Laryngectomy
_____ Swallowing Difficulties

❑ History Recurrent Pneumonias (Chest Infections)
❑ Known / suspected neurological diagnosis. Specify:_____
❑ Choking (suspected airway compromise)
❑ Duration of swallow difficulty. Specify: _____

_____ Other: Specify: _____

_____ Voice: Specify:

❑ Evidence of Hyperfunction
❑ GERD
❑ Pathology of vocal folds
❑ Degree/Type of glottal closure:
Specify:_____
❑ Other pathology
Specify: _____

COMMENTS:

_____

_____

_____

_____

DATE OF REFERRAL: _____ **REFERRAL SOURCE:** _____

ADDRESS OF REFERRAL SOURCE: _____

POSTAL CODE: _____ **TELEPHONE #:** _____