SPEECH LANGUAGE THERAPY ADULT CLINIC
REFERRAL FORM

CLIENT INFORMATION

Name: **NHI number:** **DOB:** **Age:** **Gender: Male / Female / Transgender / Non binary / Prefer not to respond**
Address: **Telephone:** **Email:**
Ethnicity: **NZ Resident: YES / NO**
Languages spoken: **Interpreter required: YES / NO**
Occupation:
Mobility (e.g. walking with frame, wheelchair, bed bound):
NOK/Caregiver: **Relationship to client:** **Address:** **Phone number: _____ (home) _____(mobile)** **Email address:**

GP: **Address:** **Phone:**	**Other Professionals involved**: _____ ph._____ _____ ph._____

REFERRAL INFORMATION

Reason for referral:
Patient's expectations of referral:

MEDICAL/SLT INFORMATION

Aetiology/Cause of communication, swallowing, and/or voice difficulty e.g. stroke, Parkinson's, vocal nodules**:** **Date of event/diagnosis:** **Length of time post event/diagnosis (e.g. 6 months; 3 years):** **Relevant Previous Medical History:**
SLT Diagnosis (please circle)**: Communication Dysphagia (swallowing) Voice**
Brief Summary of client's current communication/ swallowing skills / voice problem:

Impact of above on client's life (e.g. relationships, hobbies, community activities, accessing services, occupation):

Previous Speech Language Therapy (SLT) input: YES / NO
If yes, please describe type, duration, frequency

Is the client currently receiving SLT: **YES/NO**

Name of Speech Language Therapist: _____
Address of Speech language therapist: _____

REFERRER INFORMATION

Referrer:	**Date:**
Address:	
Phone number:	
E-mail:	
Relationship to client:	

Consent for referral (client must consent for referral to be processed)

Signature of client: _____ Date:_____

If client is unable to sign

Signature of next of kin (NOK)_____

Name of NOK_____ **Relationship to client**_____

Signature of referrer:_____ Date:_____

Please forward completed referral form to us **with any other relevant reports**:
E-mail: Clinics (Clinics@auckland.ac.nz)

Post: Speech Language Therapy Clinics,
28 Park Avenue, Grafton, Auckland 1023

For University Clinic Use only

Date referral received: _____

Date therapist alerted: _____

Therapist decision regarding referral:

- ☐ Accepted – offered an appointment
- ☐ Accepted – placed on waiting list
- ☐ Not accepted. Reason: _____

_____

Date acknowledgement of referral sent: