CLINICS
SPEECH-LANGUAGE THERAPY

Referral Form – Children

please email this completed form to clinics@auckland.ac.nz

Name of Child:		Gender:	
Date of Birth:		Age:	NHI if known:
Address:			
Parent's / Caregiver's full names:			
Ethnicity:	Language/s spoken at home: Language/s spoken at school:	If you need an interpreter, which language?	

Consent gained from parents for referral to University student clinics? Are the family willing and able to attend appointments during term time and school hours Has the child been referred to us before?	
What is the main concern?	
Name of GP:	GP's Surgery Address:
Please provide the name, address and phone number of other professionals involved (if any):	
Speech Language Therapist	
Paediatrician	
Audiologist	
Occupational Therapist	
Other	
Pre-school / Kindy / School Address:	Teacher: Phone number:
Hearing check done? Approx date:	Grommet(s) currently in situ?
Any other relevant information (**please attach relevant reports or add additional information such as medical or educational**). Include any food allergies or diet restrictions:	
Name of person completing this form: Date of referral:	Relationship to Client: