SPEECH HENS

"COMMUNICATE WITH CONFIDENCE"

Request for Private Speech-Language Pathology Services

Please complete this form in full and fax it to (226) 400-6514 with a copy of the patient profile.

Patient Name: _____ **HCN:** _____

Address: _____ **City:** _____

Postal Code: _____ **DOB:** _____ **Phone:** _____

Email (if applicable): _____

☐ **Referral from Community** ☐ **Referral from Hospital**

Consent to Referral:

☐ The patient or lawfully authorized substitute decision maker has consented to this referral

☐ Please contact the person below (rather than the patient) for assessment, due to:

☐ Patient Preference ☐ Cognitive Status ☐ Other:

☐ Hearing Difficulties ☐ Language Difficulties

Contact Person: _____ Relationship: _____

Phone (Primary): _____ Phone (Secondary): _____

Primary Care Physician: _____ Phone: _____

Primary Diagnosis: _____ **Date:** _____

Secondary Diagnosis: _____

Diagnosis Discussed: ☐ With Patient ☐ With Family

Prognosis: ☐ Improvement ☐ Remaining Stable ☐ Deterioration

Prognosis Discussed: ☐ With Patient ☐ With Family

28 Argyle St, Simcoe, ON N3Y 1V5

226-534-9457 info@speechhens.com www.speechhens.com

For a fillable PDF version of this form please visit our website: Services > Adult Services.

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"Communicate with Confidence"

Surgical Procedure: _____ **Date:** _____

Current Medications: ☐ Medication List Attached ☐ Health Profile Attached

WSIB Claim: ☐ Yes ☐ No

Allergies: _____ **Special Diet:** _____

Reason for Referral:

☐ Speech ☐ Communication ☐ Voice

☐ Language ☐ Swallowing ☐ AAC

Briefly describe main complaint:

Thank you for your referral. For any questions please call 226-534-9457 Mon-Fri.

Name: _____ **Phone:** _____

☐ **MD** ☐ **ND** **CPSO/CNO #:** _____

Signature: _____ **Date:** _____

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