

***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):			
Caregiver:		Relationship to client:	
Address:			
Phone number: _____ (home) _____ (mobile)			
Email address:			

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

Name _____ **Relationship to client** _____

Signature of next of kin _____

Signature of referrer: _____ **Date:** _____

Please forward completed referral form to us **with any other relevant reports:**

E-mail: Clinics@auckland.ac.nz

Phone: 09 9239909 option 2

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: