|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of child:** | |  | | | | | |
| **Date of birth:** | |  | | | | | |
| **Referrer’s name:** | |  | | | | | |
| **Referrer’s contact details:** | | | | | | | |
| **Address**: |  | | | | | | |
| **Phone**: . | | | | | | **Email**: | |
| **Relationship to child:** | | | Caregiver  Other | | | | |
| **If other, please specify:** | | | |  | | | |
| **Parent/caregiver’s names:**  **(if not provided above)** | | | | | . | | |
| **Parent/caregiver’s contact details (if not provided above):** | | | | | | | |
| **Address**: |  | | | | | | |
| **Phone**: . | | | | | | **Email**: | |
| **School/pre-school name:** | | | | | | **School/pre-school address:** | |
| **Other professionals involved e.g. paediatrician:** | | | | | | | |
| **Names and designations:** | | | | | | **Contact details:** | |
| . | | | | | | . | |
|  | | | | | |  | |
| **Most recent hearing test (audiogram) and tympanogram results (if relevant) and dates:** | | | | | | | |
| **Please describe the main concerns about this child’s speech, language, or auditory processing:** | | | | | | |

**I agree for my child to be assessed by the Listening and Language Clinic.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/caregiver’s signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referrer’s signature Date**

Please return completed form with all relevant reports (or you can call the clinics and the referral can be made over the phone directly with a speech language therapist):

The University of Auckland Clinics

Listening and Language Clinic

Private Bag 92019,

Auckland, 1142

**Email**: [clinics@auckland.ac.nz](mailto:clinics@auckland.ac.nz)

**Fax**: 09 303 5978

**Phone**: 09 923 9909

**Physical address:** Ground Floor, Gate 1, 261 Morrin Road, Glen Innes, Auckland.

**For UoAC use only:**

Referral not accepted and referrer advised Date: \_\_\_\_\_\_\_\_\_\_\_\_ Initial: \_\_\_\_\_\_\_\_\_

Referral not accepted and referrer advised of alternate services Date: \_\_\_\_\_\_\_\_Initial: \_\_\_\_\_\_

SLT accepts referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructions for CST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CST confirms appointment time Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial: \_\_\_\_\_\_\_\_\_

CST advised client appointment details/fees Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initial: \_\_\_\_\_\_\_\_\_

Confirmed that person paying fees will be: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact details (if not above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account will be paid by:  Cash  Credit Card  Cheque  Direct credit