|  |  |
| --- | --- |
| **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

**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