SPEECH AND LANGUAGE SERVICES
NORTH SHORE COMMUNITY HEALTH SERVICES
CENTRAL COMMUNITY HEALTH CENTRE
132 WEST ESPLANADE AVE 5TH FLOOR
NORTH VANCOUVER, B.C. V7M 1A2
TEL: (604) 983-6760 FAX: (604) 983-6839
Email: nsslp@vch.ca

SPEECH AND LANGUAGE SERVICES
REFERRAL FOR SPEECH AND LANGUAGE ASSESSMENT

Please Complete Both Sides of this Form

CHILD'S NAME: _____ BIRTH DATE: _____
(FIRST) (LAST) (MONTH / DAY / YEAR)

CHILD'S PERSONAL HEALTH NUMBER: _____ GENDER: ☐Male ☐Female

ADDRESS: _____ POSTAL CODE: _____
(STREET) (CITY)

TELEPHONE: HOME: _____ WORK: _____ CELL: _____

PARENTS / LEGAL GUARDIANS: _____ _____
(PARENT 1) (PARENT 2)

E-MAIL ADDRESSES _____ _____

LANGUAGE(S) SPOKEN AT HOME: _____ Is child a Squamish Nation Member?

INTERPRETER NEEDED: ☐YES ☐NO ☐YES ☐NO

PRESCHOOL / DAYCARE: _____

FAMILY PHYSICIAN: _____ TELEPHONE: _____

DESCRIPTION OF PROBLEM: _____

PERTINENT MEDICAL CONDITIONS: _____

DEVELOPMENT (ANY CONCERNS): _____

FAMILY HISTORY OF SPEECH, LANGUAGE, OR HEARING PROBLEMS:D _____

OTHER AGENCIES PROVIDING SERVICE TO CHILD:

☐ SPEECH LANGUAGE PATHOLOGIST (OTHER) ☐ AUDIOLOGIST ☐ PEDIATRICIAN
☐ OCCUPATIONAL THERAPIST ☐ PHYSIOTHERAPIST ☐ PSYCHOLOGIST
☐ INFANT DEVELOPMENT PROGRAM ☐ SUPPORTED CHILD CARE DEVELOPMENT PROGRAM
☐ CENTRE FOR ABILITY ☐ OTHER_____

NAME OF REFERRAL SOURCE: _____ SIGNATURE: _____

AGENCY: _____ DATE: _____

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PLEASE DESCRIBE YOUR CHILD'S COMMUNICATION BELOW:

DOES YOUR CHILD APPEAR FRUSTRATED BY HIS/HER DIFFICULTY TALKING?

☐NEVER ☐SOMETIMES ☐FREQUENTLY

DO STRANGERS HAVE DIFFICULTY UNDERSTANDING YOUR CHILD'S SPEECH?

☐NEVER ☐SOMETIMES ☐FREQUENTLY

DOES YOUR CHILD UNDERSTAND QUESTIONS AND FOLLOW DIRECTIONS?

☐NEVER ☐SOMETIMES ☐FREQUENTLY

DID YOUR CHILD BABBLE (MAKE A VARIETY OF SPEECH SOUNDS) AS A YOUNG CHILD?

☐NEVER ☐SOMETIMES ☐FREQUENTLY

HOW DOES YOUR CHILD USUALLY LET YOU KNOW WHAT HE OR SHE WANTS? CHECK ALL THAT APPLY

☐ CRIES	☐ USES SOUNDS	☐ USES MANY WORDS
☐ POINTS	☐ USES MANY SOUNDS	☐ 2 OR 3 WORD SENTENCES
☐ USES GESTURES	☐ USES A FEW WORDS	☐ USES LONG SENTENCES

PLEASE GIVE SOME EXAMPLES OF WHAT YOUR CHILD SAYS:

DEVELOPMENTAL MILESTONES:

AT WHAT AGE DID YOUR CHILD?

SIT ALONE_____WALK_____ BECOME TOILET TRAINED _____

USE SINGLE WORDS_____USE 2 OR 3 WORD PHRASES _____

SPEECH & LANGUAGE SERVICES CONSENT

I_____PARENT/GUARDIAN OF:_____GIVE PERMISSION
(Parent/Guardian's name) Child's name)

FOR THE SPEECH AND LANGUAGE PROGRAM AT VANCOUVER COASTAL HEALTH NORTH SHORE TO:

1. COMMUNICATE WITH ME ABOUT MY CHILD'S APPOINTMENTS VIA E-MAIL ☐YES☐ NO
2. CARRY OUT AN EVALUATION OF MY CHILD'S SPEECH AND LANGUAGE SKILLS ☐YES☐ NO

SIGNED (PARENT/GUARDIAN):_____ DATE: _____

**ACKNOWLEDGEMENT OF THIS REFERRAL WILL BE MADE BY AN EMAIL.
YOUR CHILD WILL ALSO BE REFERRED TO THE HEARING CLINIC**