



**Speech Pathology Referral**

U.R Number .....  
Surname .....  
Given Name(s) .....  
Date of Birth .....

**AFFIX PATIENT LABEL HERE**

**IDENTIFY** (Patient details as above)

Home phone number..... Mobile phone number.....  
Address.....  
Primary language..... Interpreter required  Yes  No  
GP details.....

**SITUATION**

Reason for referral  Swallowing  Speech  Language  Voice  Other  
Description of the problem.....  
.....  
.....

**BACKGROUND**

Medical history (including details regarding recent admissions to hospital).....  
.....  
.....

**ASSESSMENT**

Details of any relevant assessments.....  
.....  
.....  
Current oral diet.....

**REQUEST/RECOMMENDATIONS**

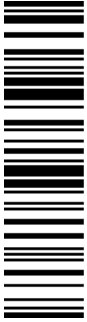
New assessment  Voice Analysis Clinic  
 Videofluoroscopic swallowing study  Fiberoptic endoscopic evaluation of swallowing  
 Ongoing intervention. Provide active goals.....  
.....  
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Referrer name.....Designation.....  
Date.....Contact number.....

Please fax this referral to 9496 2947 or send to Speech Pathology Outpatients, Grevillea Centre, Heidelberg Repatriation Hospital, PO Box 5444, Heidelberg West, 3081

Speech Pathology – Outpatient Services Referral

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