Austin HEALTH

Speech Pathology Referral

U.R Number ……

Surname ……

Given Name(s) ……..

Date of Birth ……..……

AFFIX PATIENT LABEL HERE

FAH067077

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……

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……..……

BACKGROUND

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

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ASSESSMENT

Details of any relevant assessments……..

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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

C1.3

08/2016