



**SPEECH-LANGUAGE PATHOLOGY
REFERRAL FORM – ADULT**

- P.O. Box 2005
Corner Brook, NL
A2H 6J7
Telephone: (709) 784-5374
Fax: (709) 637-5381
- Rehabilitation Annex
127 Montana Drive
Stephenville, NL
A2N 2T4
Telephone: (709) 643-8690
Fax: (709) 643-3944
- P.O. Box 100
3-9 Barhaven Drive
Port aux Basques, NL
A0M 1C0
Telephone: (709) 695-4523
Fax: (709) 695-2845
- 20 Farm Road
Deer Lake, NL
A8A 1J3
Phone: (709) 635-7894
Fax : (709) 635-5211

CLIENT INFORMATION: (Please fill in ALL information below)

NAME: _____ **Gender:** _____
(first) (middle) (last)

MCP#: _____ **DOB:** _____
(year) (month) (day)

ADDRESS: _____
(street/post office box) (city/town) (postal code)

NEXT OF KIN: _____ **RELATIONSHIP:** _____

TELEPHONE #: (home) _____ (work) _____

REFERRAL INFORMATION: * **Check the reason for referral**

- _____ Articulation (Pronunciation)
- _____ Stuttering
- _____ Stroke/Head Injury
- _____ Laryngectomy
- _____ Swallowing Difficulties
- _____ Other: Specify: _____
- _____ Voice: Specify: Evidence of Hyperfunction
- GERD
- Pathology of vocal folds
- Degree/Type of glottal closure:
Specify: _____
- Other pathology
Specify: _____

COMMENTS:

DATE OF REFERRAL: _____ **REFERRAL SOURCE:** _____

ADDRESS OF REFERRAL SOURCE: _____

POSTAL CODE: _____ **TELEPHONE #:** _____

