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School-Age Client Form

Today's Referral Date: ___________________

<u>Family Information:</u>

Child's Name: _________________________________
Date of Birth:_________________

Name of Parents/Guardians: ____
Address: ____
e-mail Address: ____
Phone Number: (H)________________ (W)________________

Siblings: Name(s)/Age(s):____
____
Languages spoken at home: ____

<u>Medical Information:</u>

Referral source: ____

Reason for this referral: ____
____

Has your child been seen previously by a Speech-Language Pathologist? __________
If so, what were the goals and the outcome? ___________________________________
____

Name/Address of family Physician:____
____

Are there other health professionals involved (e.g. Audiology, Psychology?)
____
____

Please list pertinent medical Diagnoses:
____

Other Background Information:

Any family history of speech and/or language problems?
____

Please indicate the date of your child's most recent hearing test and results:
____

Please describe any difficulties your child experienced in acquiring speech and/or language.
____
____

School:

School attended: __________________________ grade: _______
Teacher's Name:__________________________

Have there been concerns raised by the child's classroom teacher?
____

Does your child communicate effectively with peers?
____

Does your child receive any kind of additional support in school? For instances, Resource or EPA support?____
____

Please check areas of development that are of concern:

- Play skills
- Behavior
- Eating/swallowing/food textures
- Speech production
- Fluency
- Voice
- Comprehension of language
- Expression of language (combining words)
- Social interaction
- Sensory/self-regulation
- Other: ____

Briefly describe the nature of your child's speech and/or language problem:
____
____

What would you most like to see your child achieve?
____

How did you find out about our services?

- At Home Speech & Language Services website
- Yellow Pages
- Speech and Hearing Association Nova Scotia (SHANS)
- Other