Interior Health

Speech & Language Clinic

Request For Services

☐ **Speech/Language (0-5 Years)**

☐ **Hearing**

LAST NAME: FIRST NAME:			**DATE OF REFERRAL** ☐ MALE ☐ FEMALE
ADDRESS (including postal code)			HOME PHONE ALTERNATE PHONE LANGUAGES SPOKEN
BIRTHDATE (DAY/MO/YR)	AGE	CARE CARD NUMBER	PHYSICIAN
PARENTS / GUARDIANS			HAS PARENT/GUARDIAN BEEN NOTIFIED PRIOR TO REFERRAL? ☐ Yes ☐ No

DESCRIPTION OF CONCERNS (Required)

OTHER HEALTH PROFESSIONALS/AGENCIES INVOLVED

REFERRAL SOURCE

NAME

If a self referral how did you hear about the service?

FACILITY/AGENCY PHONE NO.

ADDRESS CITY POSTAL CODE

RELATIONSHIP OF REFERRAL SOURCE TO CLIENT:

☐ PARENT/GUARDIAN ☐ PHYSICIAN ☐ AUDIOLOGIST ☐ SPEECH/LANGUAGE PATHOLOGIST

☐ PHN ☐ IDP ☐ OTHER

RETURN TO: (Mail or Fax)

Speech & Language Clinic
Salmon Arm Health Centre
Box 627 851 16th St. N.E.
Salmon Arm, B.C. V1E 4N7
(250) 833-4100 Fax (250) 833-4117