BURNIE:	73 – 75 Mount Street
DEVONPORT:	70 Oldaker Street
LAUNCESTON:	50b Frankland Street
BELLERIVE:	9 – 11 Cambridge Road
ROSEBERY:	3 Reece Avenue

My Speech Pathology Tasmania
ABN: 91 428 242 665
73-75 Mount Street, Burnie TAS 7320
PO Box 510, Burnie TAS 7320
p 03 6431 8411 | **f** 03 6431 1417
e admin@myspeechpathology.org.au

Referral – Speech Pathology

Client Details

Client Name:					
Date Of Birth:		Age:		Gender / Pronoun	
Address:					
Email:			Phone:		
Next of Kin / Guardian: *(if applicable)*	Name:				
	Relationship:				
	Phone:				

Referrer Details

Referral Date:			
Referrer Name and Title:			
Referrer Organisation:			
Address:			
Email:		Phone:	

Reason for Referral

(Please provide information about your key concerns so that we can determine how to best meet the needs of the client. Extra information can be attached if required.)

- ☐ **Speech** (eg unclear speech, difficulty being understood)
- ☐ **Language** (eg difficulty understanding and using language, not talking, minimal spoken words)
- ☐ **Alternative Communication** (eg assistive communication systems)
- ☐ **Voice** (eg hoarse voice, losing voice, vocal nodules)
- ☐ **Stuttering** (stammering)
- ☐ **Literacy** (reading, writing)
- ☐ **Mealtime Difficulties** (eg fussy eater, sensory sensitivities, limited food variety)
- ☐ **Swallowing** (eg swallowing difficulties, choking, coughing)
- ☐ **Other**

Relevant History/Information: *(Include any past/current diagnoses and/or medical conditions)*	
Other Current Therapists / Services engaged with: *Please provide details and contact details if possible*	☐ Occupational Therapy ☐ Dietitian ☐ ENT ☐ Neurologist ☐ Gastroenterologist ☐ Paediatrician ☐ Psychologist / Behavioural specialist ☐ Other
Relevant reports or plans to be provided: *Please attach to referral or provide details prior to service*	☐ Asthma/Anaphylaxis Plan ☐ Relevant Court Orders / Legal matters ☐ Medical/Therapy reports ☐ NDIS goals ☐ Other

Funding – *Note – some services may attract a gap fee, contact us to discuss if unsure.*

NDIS:	Participant Number: Plan start date: ___________________ Plan finish date: ___________________ ☐ NDIA ☐ Plan managed ☐ Self-managed Plan Manager (if applicable): ____ Person responsible for payment: ____ Available funds / hours for Speech Pathology: ____________________________		
MEDICARE*:*	Number:	IRN:	Expiry Date:
DEPT VETERAN AFFAIRS::	Number:		Expiry date:
HCP:			
CHSP:			
HACC:			
Private Health Fund:	Fund Name:	Number:	Expiry Date:

Please send all referrals to:

My Speech Pathology
PO BOX 510
Burnie TAS 7320

email: admin@myspeechpathology.org.au
fax: **03 6431 1417**