Eastern Ranges
GP Association

RURAL PRIMARY HEALTH SERVICES PROGRAM
SPEECH PATHOLOGY

REFERRAL FORM

Student's Name:	**School:**
Date of Birth: / / Age:	**Grade:**
Parent/Caregiver:	**Teacher:**
	Ph.
Address:	**Email:**
	Referred by:
Home phone:	**Ph:**
Mobile:	**Email:**
Email:	**Date of referral:**

Reason for referral :

Articulation (speech sounds)	
Comprehension difficulties	
Spoken language problems	
Voice disorders (eg hoarseness)	
Fluency (stuttering)	
Literacy or learning difficulties	

Other: _____

Other professionals involved :

Psychologist	
Social worker	
GP/Paediatrician	
Audiologist	
Eye Specialist	
Other	

Details: _____

Child meets the following criteria:

- ❑ Lives in one of the following townships - Marysville, Healesville, Yarra Glen, Yarra Junction, Warburton
- ❑ Child is in Grade Prep or will be in Grade Prep in 2012
- ❑ Not currently receiving Speech Pathology services elsewhere
- ❑ Not eligible for funding under other programs – Better Start, Austism Initiative, Department of Education and Early Childhood Development (DEECD) Program for Students with disabilities (PSD) or similar
- ❑ Child is not enrolled in a Special School or Special Development School
- ❑ Parent/caregiver is willing to attend session with child and complete home practise tasks

Please fax this referral (and any relevant reports) to: 9923 6257