



**Request for consultation in Speech Language Pathology**

**■ Registration to the Clinic's Waiting List ■**

**REFERRAL DATE:** \_\_\_\_\_  
DD/MM/YYYY (p. ex., 25 02 1990)

**PERSON REQUIRING SLP SERVICES:**

Name: \_\_\_\_\_  
Date of birth (DD/MM/YYYY): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Telephone (at home): ( \_\_\_\_\_ ) \_\_\_\_\_  
Telephone (at work): ( \_\_\_\_\_ ) \_\_\_\_\_  
Cell: ( \_\_\_\_\_ ) \_\_\_\_\_  
E-mail: \_\_\_\_\_

**PERSON REFERRING:**

Name: \_\_\_\_\_  
Telephone (at home): ( \_\_\_\_\_ ) \_\_\_\_\_  
Telephone (at work): \_\_\_\_\_  
Cell: ( \_\_\_\_\_ ) \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Relationship with the person referred:  Parent  Family Member  Other  
 SLP  Family Doctor

**PLEASE CHOOSE THE CATEGORIES THAT SEEM TO CORRESPOND BEST TO THE SITUATION OF THE PERSON REQUIRING SLP SERVICES:**

- Language (child)
- Language (adult - aphasia)
- Written Language
- Articulation
- Voice
- Stuttering
- Swallowing disorders (dysphagia)
- Augmentative communication
- Autism Spectrum Disorder
- Other: \_\_\_\_\_

**DESCRIPTION OF DIFFICULTIES EXPERIENCED:**

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.....  
.....

<b>SCHOOL GRADE (IF APPLICABLE):</b>	<b>SCHOOL ATTENDED (IF APPLICABLE):</b>
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**LANGUAGE(S) FREQUENTLY USED:**

English       French       Bilingual (EnglishFrench)       Other \_\_\_\_\_

**TYPES OF SERVICES REQUESTED:**

Assessment       Intervention/Follow-up       Other \_\_\_\_\_

**EXISTING EVALUATION (PRIOR SERVICES RECEIVED):**

<b>SPEECH LANGUAGE PATHOLOGY</b> <input type="checkbox"/> Preschool Pathology (ex. : <i>Wordplay</i> ) <input type="checkbox"/> Private SLP <input type="checkbox"/> School based SLP	Date: _____ Conclusion / Recommendations: ..... ..... .....
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<b>OTHER SERVICES</b> <input type="checkbox"/> Physiotheapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Psychology/psychometry <input type="checkbox"/> Audiology o Audition o Central auditory processing <input type="checkbox"/> Optometry o Vision o Visual perceptual skills <input type="checkbox"/> Other : _____	Date: _____ Conclusion / Recommendations: ..... ..... .....
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**Please send this registration form by fax at (705) 671-3889,  
or by email at [speechclinic@laurentian.ca](mailto:speechclinic@laurentian.ca)  
or by mail at : Speech and Language University Clinic • Laurentian University  
935 Ramsey Lake Road • Sudbury (Ontario) P3E 2C6**