Saskatchewan Health Authority

Early Childhood Speech and Language Services
Saskatoon and Area

Referral Form

The following speech and language services are offered to children from **birth until the start of kindergarten**:

☐ **Saskatoon Early Childhood Speech and Language Clinic**, Royal University Hospital, for City of Saskatoon residents. Send this referral to 103 Hospital Drive, Saskatoon, SK, S7N 0W8; Fax: 306-655-2994; Email: slp.primaryhealth@saskhealthauthority.ca; or Phone: 306-655-2434

☐ **Public Health Speech and Language Services** for residents of the Saskatoon rural area. Send this referral to North East Office, 108-407 Ludlow Street, Saskatoon, S7S 1P3; Fax: 306-655-4721, or Phone 306-655-4700.

Other SLP Services available (Please DO NOT USE THIS FORM - Directly contact the specific agency listed):

- For children who display or are at risk for significant developmental, cognitive and/or physical challenges, contact the Alvin Buckwold Child Development Program at Kinsmen Children's Centre 306-655-1070.
- For children attending Saskatoon Pre-Kindergarten programs, contact your Pre-K teacher for more information regarding possible services available.
- Saskatoon Child Care Speech and Language Services are available at certain locations. Talk to the director at your child's licensed child care centre to determine if services are available. If your child's centre is not covered by this program, please refer to one of the above options.
- For school-age children, contact the child's school for speech and language services.
- For Adult SLP services, contact the Adult Speech Language Centre at City Hospital 306-655-8208.

Referral Date: _____

Child's Name: Last: _____ First: _____ ☐ Boy ☐ Girl

Personal Health Number: __ __ __ __ __ __ __ __ __ __ Birth date (dd-mmm-yyyy): __ __ - __ __ __ - __ __ __ __

Address: _____ City/Town:_____ Postal Code: __ __ __ __ __ __

Child lives with: ☐Both Parents ☐ Father ☐ Mother ☐ Foster Parents ☐ Other: _____

Family Physician: _____ Languages spoken in home: ☐ English ☐ Other: _____

Child attends: ☐ Licensed Child Care Centre ☐ Pre-Kindergarten ☐ Other/None

Name of program: _____ Address: _____

☐ Mother ☐ Other: _____

Last name: _____ First: _____

Home Phone: __ __ __ - __ __ __ - __ __ __ __ ☐ preferred

Cell Phone: __ __ __ - __ __ __ - __ __ __ __ ☐ preferred

☐ Father ☐ Other: _____

Last name: _____ First: _____

Home Phone: __ __ __ - __ __ __ - __ __ __ __ ☐ preferred

Cell Phone: __ __ __ - __ __ __ - __ __ __ __ ☐ preferred

Primary Email: _____ I/We consent to email contact ☐

1. Reason for Referral:
   - ☐Not meeting milestones at 18-20 months screening
   - ☐Low vocabulary for age: _____words
   - ☐Difficulty combining words into sentences
   - ☐Difficulty following directions or understanding language
   - ☐Speech is difficult to understand
   - ☐Stuttering
   - ☐Parent concerned? ☐No ☐Yes
   - ☐Other: _____
2. Medical diagnosis No Yes _____
3. Alcohol or drug use during pregnancy No Yes _____ ☐Unknown
4. History of ear infections No Yes (how many: _____)
5. Tubes placed in ears No ☐Yes (date: _____)
6. Other areas of concern (e.g., walking, behavior, other) No ☐Yes _____
7. Other services that the child has been referred to or has previously received:
   - ☐Alvin Buckwold Child Development Program
   - ☐Kids First
   - ☐Child and Youth Services
   - ☐Speech-Language Pathologist: _____
   - ☐Other: _____
8. Additional information: _____

Referred by: ☐PHN: _____ (☐NE ☐WW ☐SE ☐ON ☐Rosthern ☐Humboldt ☐Watrous ☐Wadena)
☐Parent ☐Dr. _____ ☐Other: _____