Adult Speech Language Centre
Saskatoon City Hospital
701 Queen Street
Saskatoon, SK S7K 0M6
Ph: 306-655-8208 Fax: 306-655-8236

Referral for Outpatient Speech and Language Services

Referral Date: ____________________

Client's Name: Last: ____________________ First: ____________________ Birth date (dd-mm-yy):______________

Personal Health Number: __ __ __ __ __ __ __ __ __ Family Physician: ____________________________

Address: ____ Postal Code: ________________

Preferred Contact #: ________________ (☐Home ☐ Cell ☐ Work) Alternate #: _______________ (☐Home ☐ Cell ☐ Work)

Next of Kin/Caregiver: __________________ Relationship: _________________________ ☐ Not Applicable

---

Diagnosis: ____ Onset: ____________________________________

Other Significant Medical History: ☐ None

☐Yes, please detail: ____

Previous Speech/Language Therapy: ☐ None ***Only refer if discharged from other Health Region SLP Services**

☐Yes: SLP: ________________________

Dates and Number of Sessions: ____

Reason for Referral:

☐ **SWALLOWING:** Clinical Evaluation or Modified Barium Swallow at SLP's discretion

☐ **VOICE:** Hoarseness, Cough, Vocal Fold Paralysis, Vocal Cord Dysfunction

☐ **SPEECH:** Articulation, Motor Speech (Apraxia, Dysarthria)

☐ **LANGUAGE:** Understanding and Use of Language, Reading, Writing

☐ **COGNITIVE SKILLS:** Memory, Reasoning, Processing Difficulties

☐ **FLUENCY:** Stuttering, Stammering

☐ **AUGMENTATIVE/ALTERNATIVE COMMUNICATION:** Limited use of verbal language

Additional Information: ____

____

____

____

Referral Source: ☐Self ☐Physician ☐SLP **(Attach Ax/Tx Summary)** ☐Other: ________________

Name: ____________________________________ Signature: ________________________

Physician's signature required if Modified Barium Swallow is requested: ______________________________

Please attach additional medical history/summary information.

Incomplete referrals will be returned. Please complete form in its entirety.