

SPEECH LANGUAGE THERAPY CLINIC

# Request for Speech Language Therapy Services: Child

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| Client Name: | | Date: | |
| DOB: | | Age: | |
| Residential Address: | | Postal Address: | |
| Parents / Carers:  Occupation: | | **Email:** | |
| Phone Home: | Phone Work: | | Mobile: |
| Language/s spoken at home: | | GP: | |
| Referred by:  Relationship: | | Other professionals consulted or involved: | |
| Which ethnic group/s do you belong to:  \_\_\_\_\_ New Zealand European  \_\_\_\_\_ Maori / Iwi \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_ Samoan  \_\_\_\_\_ Cook Island Maori  \_\_\_\_\_ Tongan  \_\_\_\_\_ Niuean  \_\_\_\_\_ Chinese  \_\_\_\_\_ Indian  \_\_\_\_\_ Other (such as Australian, Dutch,  Japanese, South African,  Tokelauan) Please state:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Has the client had any speech language therapy Assessment or Intervention:  Yes: \_\_\_\_\_ No: \_\_\_\_\_  If yes:  Name of therapist:  Date/s:  Organisation (e.g. Ministry of Education):  Current School / Pre School:  Level:  Teacher: | |

### Caregiver’s Concerns (please state in your own words and attach any relevant reports or documents)

**Comment on the following aspects:**

**Hearing**

**Speech**

**Language**

**Communication**

# *The information you provide, particularly a detailed account of your concerns, will enable us to allocate you to a student with the appropriate skills Once your have been offered a place, a comprehensive interview will be conducted.*

**Return to:**

[sltclinic@massey.ac.nz](mailto:sltclinic@massey.ac.nz)

or

MUSLT Clinic Private Bag 102-904 Albany 0745 Auckland

*Thank you*