

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

or

MUSLT Clinic Private Bag 102-904 Albany 0745 Auckland

*Thank you*