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Community Pediatric Audiology and Speech-Language Program
Request for Services

Please complete all sections of form. Incomplete referrals may be returned.

Referral Date *(dd/mmm/yyyy)*	Personal Health Number	Sex ☐ Female ☐ Male	
Client's Name *(surname, first name)*		Date of Birth *(dd/mmm/yyyy)*	Age (CCA)
Address *(including postal code)*		Postal Code	
Parent/Guardian	Parent/Guardian		
Home Phone	Cell Phone	Work Phone	
Name of School	Language spoken by client ☐ English ☐ Other, specify	Interpreter Required ☐ Yes ☐ No	
Family Physician's Name			

Please check all relevant boxes and provide as much detail as possible.

☐ Request for Audiology (0 to 19 years)

☐ **Urgent Request for Audiological Assessment**
- ☐ **Suspected hearing loss (not related to middle ear fluid /infection)**
- ☐ **Ear trauma, specify** _____

☐ **Regular Request for Audiological Assessment**
- ☐ **Middle ear concerns**
- ☐ **Pre/Post-surgery audiogram**
- ☐ **Little or no interest in sound/fleeting attention**
- ☐ **No babbling or cooing/stopped babbling or cooing**
- ☐ **Swim molds**
- ☐ **Other, specify:** _____

☐ Request for Speech-Language*(0 to 5 years)

- ☐ **Difficult to understand**
- ☐ **Difficulty forming sentences**
- ☐ **Stutters/repeats words**
- ☐ **The child appears to not understand language and cannot follow directions**
- ☐ **Few words for age**
- ☐ **Voice problem (scratchy, raspy or nasal sounding)**
- ☐ **Behaviour (e.g. aggression, tantrums, impulsiveness, difficulty with social skills)**
- ☐ **Concerns for autism or developmental delay**
- ☐ **Other, specify:** _____

*Services may be provided by The Centre for Child Development, Reach Child and Youth Society, Surrey Early Speech & Language Program or Fraser Health for children living in Delta, Surrey, Langley or White Rock.

If there are concerns for autism or developmental delay, specify:

Has a sibling been referred for Speech-Language services? No ☐ Yes ☐ Clinic/Centre Name:

REQUIRED: Parent/guardian is aware of this referral and understands it may be forwarded to other service providers.
Signature of parent or referral source: _____

Previous, current, or waitlisted (if known) physicians, specialists, testing, or clinics attended.

☐ Autism/Developmental Assessment	☐ Ear, Nose and Throat Specialist	☐ Pediatrician
☐ Infant Development Program	☐ Supported Child Development Program	☐ Occupational Therapist/Physiotherapist

Referral Source	☐ Family Doctor	☐ ENT	☐ Pediatrician	☐ Parent/Guardian
	☐ Public Health Nurse	☐ Audiologist/S-L Pathologist	☐ Other, specify _____	

Name	Phone	Fax
Address		Postal Code
Referral Taken By *(please print name)*	Designation	

Please note that it is the responsibility of the referring source to fax the completed referral form to the numbers indicated below. Depending on the service(s) provided at each clinic, you may have to fax your referral to more than one location. Services are provided based on client/patient's city of residence.

AUDIOLOGY SERVICES		
CLINIC	**FAX**	**PHONE**
Abbotsford	**604-864-3410**	604-864-3468
Burnaby	**604-918-7660**	604-918-7663
Chilliwack	**604-702-4971**	604-702-4944
Cloverdale and White Rock	**604-574-2091**	604-575-6381
Guildford	**604-587-4777**	604-587-4751
Langley	**604-530-8138**	604-539-2904
Maple Ridge and Mission	**604-476-7077**	604-476-7070
New Westminster, Port Moody, Coquitlam and Port Coquitlam	**604-525-3803**	604-777-6855 Ext. 526616
North Delta	**604-591-7382**	604-507-5404

SPEECH-LANGUAGE SERVICES		
CLINIC	**FAX**	**PHONE**
Abbotsford	**604-864-3410**	604-864-3435
Burnaby	**604-918-7660**	604-918-7663
Central Referral Office (provides referral services to Delta, Langley, Surrey, and White Rock)	**604-583-5113**	604-587-4273
Chilliwack	**604-702-4971**	604-702-4944
Coquitlam *Fax all speech-language referrals to the **Tri-Cities Children's Services (SHARE): 604-525-3013**		
Maple Ridge	**604-476-7077**	604-476-7070
Mission	**604-814-5517**	604-814-5500
New Westminster	**604-525-3803**	604-777-6855 Ext. 526616
Port Coquitlam/ Port Moody	**604-949-7211**	604-949-7213