**Georgetown Hospital**
**1 Princess Anne Drive**
**Georgetown, ON L7G 2B8**
**Phone: 905-873-0111 ext. 8112**
**Fax: 905-873-4567**

**Dept. of Rehabilitation**

# SPEECH PATHOLOGY OUT-PATIENT REFERRAL

Surname: _____ First Name: _____ G#:_____

Date of Birth (d/m/y): _____ Health Card#: _____Version Code:_____ Sex: M F

Address: _____
(# and Street Name) (Town/City) (Postal Code)

Telephone – Home: _____ Business: _____

Contact Name: _____ Phone # (if different than patient): _____

Referring Physician: _____ Family Physician: _____

**REASON FOR REFERRAL ( Please check those that apply)**

1) Assessment and Treatment of:
- ❒ Aphasia (communication disorder CVA, TBI, etc.)
- ❒ Voice Disorders
- ❒ Speech Disorders (apraxia, dysarthria, other)
- ❒ Dysphagia including Videofluoroscopic Swallowing Study

2) Other: _____

**DIAGNOSIS**: _____

_____

Date of Onset: _____ Date of Surgery: _____

Current Medications: _____

Comments: _____

Additional Reports to: _____

***Physician's Signature:*** _____ ***Date:*** _____

**FOR OFFICE USE ONLY -** Intake Date: _____ Booked: _____