



NEW CLIENT REFERRAL FORM

Date: Click or tap to enter a date.

Exclusion Criteria - Please note we are not an acute clinic and **ARE NOT ABLE TO** accept clients where there is:

- ☒ Acute dysphagia ☒ Moderate-severe mental health/behavioural needs
☒ Risk of suicide or self-harm ☒ Drug or alcohol abuse / dependence ☒ End-of-life/palliative care

CLIENT DETAILS

Title:	Surname:	Given name/s:	
Preferred name:			Date of Birth:
Birth Sex: ☐ Female ☐ Male ☐ Prefer not to state		Gender:	Pronouns:
Are you of Aboriginal or Torres Strait Islander Origin? ☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander			
Address:			
Phone Contact (1):		Phone Contact (2):	
Email:			
English as a Second Language: ☐ YES		Preferred Language:	
Interpreter required? ☐ Yes ☐ No			

EMERGENCY CONTACT/NEXT OF KIN

Name:	Relationship to Client:	
Email:	Contact Number:	
I give permission for my emergency contact/next of kin to be contacted by a Curtin staff member in an emergency:	☐ YES	☐ NO

REFERRER INFORMATION

☐ Self-Referral (<i>if self-referring, please proceed to "Service Requested" section</i>)	
☐ Health Professional/Other (<i>please complete the following details</i>)	
Consent for Referral to Clinic Obtained: ☐ Yes ☐ No	
Name:	
Professional Designation:	
Service/Organisation:	
Address:	
Contact Number:	
Email:	

SERVICE REQUESTED

☐ Speech Pathology individual sessions ☐ Social communication groups	
We can offer Telehealth appointments.	
Please indicate if this is: ☐ Required ☐ Preferred ☐ Not Applicable	



Referral Details

Reason for referral:

Current and Previous Medical History:

Please list all relevant diagnoses, all health professionals that have been involved e.g. GP, Specialists, Psychologist, Speech Pathologist, Physiotherapist, Occupational Therapist etc. (attach separate medical history and reports if suitable).

ACCESSIBILITY/SUITABILITY

Is the client mobile? ☐ Yes ☐ No

(If no) Does the client have support in place for mobility issues, or will someone attend with them? ☐ Yes ☐ No

Does the client have reliable transport to the clinic? ☐ Yes ☐ No

Details:

Does the client use a communication device?
☐ Yes ☐ No

Details:

If your referral is for voice-related concerns, has the client seen an ENT and/or had a videostroboscopy/nasendoscopy? ☐ Yes ☐ No

(If yes) Please attach report

Does the client have a pre-existing diagnosis of Dysphagia (swallowing problems)? ☐ Yes ☐ No

(If yes) Is the client receiving active treatment and/or monitoring for this by an external Speech Pathologist?
☐ Yes ☐ No

Is the client able to commit to attending **weekly** sessions on a regular basis? ☐ Yes ☐ No

(If no) Details:

CLINIC CONTACT DETAILS

Please email completed referral form to curtinclinics404-adultspeech@curtin.edu.au or phone **(08) 9266 1717** if you have any questions about this referral form or process.

PLEASE NOTE: The Clinic is student-led, and services are provided by students under the guidance of qualified professionals. Clinics run over an 8-week student block. Not all referrals are appropriate for a student learning environment and will be assessed by our team prior to acceptance. If you are suitable for the clinic, we may be in contact to invite you to an initial assessment session. We aim to be in contact within **2 weeks** of your referral being received.



Admin use only

Client contacted

Date:

Initials:

Referral accepted?

☐ Yes ☐ No

Screening booked

Date:

Notes: