PERSONAL INFORMATION

Client name:					
Date of Birth:		Age:		Gender:	
Parent/carer:					
Address:					
Phone	H:		M:		
Email:					
Do you consent to receiving SMS / Email?	Yes / No SMS Email				
Aboriginal/TSI: (please Circle)	Aboriginal	Torres Strait Islander	Neither	Not identified	Other cultural identity:
Regular GP's name:					
GP Practice:					

ALTERNATIVE CONTACT

Name:		Relationship:	
Address:			
Phone	Work:	Home:	Mobile:

REFERRAL INFORMATION

Date of referral:	
Did someone recommend a referral?	Name: Parent/Carer/Preschool/Day care Centre/School /GP/Other (please circle)

ADDITIONAL REFERRAL INFORMATION

Do you know what speech pathologists do?

Speech Pathologists can help with speech sounds, listening, understanding what people say, putting words into spoken or written sentences to get your message across to other people, talking with peers, reading and writing, stuttering, and hoarse or unusual sounding voices.

This service is supported by funding from Western NSW Primary Health Network through the Australian Government's PHN Program

Can you tell me more about why you think _____ needs to see a speech pathologist?

1.
2.
3.

Has your child ever had a hearing test?

Yes ☐
No ☐

If yes, when ____and results; _____

If not, and they are concerned about speech and have a history of ear infections or hearing difficulties, please encourage them to contact their local community health or preschool/school for a hearing test.

Has your child ever been diagnosed with any other condition?

Yes ☐
No ☐

If yes please specify:

Are you concerned about other areas of development? E.g. running, jumping, remembering information

Does your child receive therapy services (or have they been referred to) any other agencies?

☐ Private Occupational Therapy. Please specify: _____

☐ Private Speech Pathology. Please specify: _____

☐ Community Health Centre

☐ Mackillop Family Services/Barnardos

☐ NDIS Services. Please specify: _____

☐ School Counsellor

☐ Paediatrician

☐ Ear, Nose and Throat Specialist

☐ Child & Family Health Nurse

☐ Royal Far West

Other: N/A

****THIS SECTION MUST BE COMPLETED BEFORE SUBMITTING THE REFERRAL****

☐ I have had a conversation with the parent/carer about why I am recommending a referral to a Speech Pathologist.

☐ We have identified (name of parent/teacher/aide)…….. to work with this child for a minimum of two sessions a week on the identified communication goals.

…….. (name of person completing the form)

…… (signature of person completing the form)

Speech Pathology Client Consent

Marathon Health is committed to providing you with the highest level of service and confidentiality. Marathon Health is bound by the Commonwealth Privacy Act 1998 and the Privacy Amendment (Private Sector Act 2000).

Collection, exchange and disclosure of information

I consent to;

- ☐ The collection of information during the process of treatment under the Allied Health program co-ordinated by Marathon Health.
- ☐ The sharing of information obtained under treatment to be exchanged with other agencies as may be required and as is relevant to my treatment and goals. E.g. GP, other health professional, school
- ☐ The use of information obtained through my treatment to be used anonymously for Marathon Health purposes, including but not limited to the Department of Health reporting, service evaluation and reviews.

Confidentiality

I acknowledge;

- ☐ That all information obtained under the treatment of the Allied Health program is strictly confidential except in particular circumstances. I acknowledge allied health clinicians have a duty of care to disclose information that identifies me or any other person at risk of harm. Additionally; information subpoenaed by a court of law and or requested under Chapter 16A of the Child and Young Person (Care and Protection) Act 1998 is also exempt from client confidentiality.
- ☐ That all information regarding my treatment will be stored securely in a locked place. At any time I may request to see information held in this file.
- ☐ That I may withdraw from treatment at any time.

Telehealth

- ☐ If telehealth is deemed an appropriate mode of service delivery, I consent to receiving therapy via Telehealth.

Parent/Legal Guardian Name	**Parent/Guardian Signature**	**Date**
_____	_____	_____

I am satisfied that the client and or legal parent/guardian understands the proposed collections, use and disclosure of personal health information and has provided informed consent.

Health Provider Name	**Health Provider Signature**	**Date**
_____	_____	_____