# Referral Form – Pediatric Stuttering/Cluttering Service

**Fax # 613-526-7126**

## Child's Personal Information

| | | | | |
|---|---|---|---|---|
| First name | Last name | Date of birth (dd/mm/yyyy) | Age | Gender ☐ M ☐ F ☐ Other |
| Address Apt. City | | Province Postal Code | | Preferred Pronouns |
| Primary Phone # | Secondary Phone # | Languages spoken ☐ English ☐ French ☐ Other (specify) | | |
| Is your referral related to a specific diagnosis or any specific observations? ☐ No ☐ Yes (please specify) | | | | |
| Source of referral (How did you hear about the clinic?) ☐ Medical Referral ☐ Online ☐ Word of Mouth ☐ Other: | | | | |
| Any medical conditions or allergies? ☐ No ☐ Yes (please specify) | | | | Insurance Coverage: ☐ No ☐ Yes |

**Guardianship:** ☐ Joint ☐ Sole (please specify): ☐ Other (please specify):

| **Parent/Guardian #1** | Language: ☐ En ☐ Fr | **Parent/Guardian #2** | Language: ☐ En ☐ Fr |
|---|---|---|---|
| First name | Last name | First name | Last name |
| Phone #: | Relationship to the child | Phone #: | Relationship to the child |

**Reason for Referral:** _____

## The child shows difficulties with (select all that apply)

| | | |
|---|---|---|
| Completing daily activities: ☐ Personal care (hygiene, dressing, eating) ☐ Hobbies/ leisure (arts,sports, listening to music) ☐ Academic activities ☐ Social activities ☐ Tasks at home/ chores | | |
| Listening and understanding/ comprehension: ☐ Following conversations in noisy environments ☐ Following instructions ☐ Asks frequently for repetitions ☐ Takes time to respond | | |
| Speaking: ☐ Trouble finding words ☐ Pronunciation/ articulation of sounds ☐ Stuttering | | ☐ Retaining information |
| Reading: ☐ Decoding words ☐ Text comprehension ☐ Confuses letters | | |
| Writing: ☐ Holding a pencil ☐ Letter formation/ numbers ☐ Organizing ideas ☐ Grammar/ spelling | | |
| Physical aspects: ☐ Posture ☐ Balance ☐ Strength ☐ Coordination | ☐ Managing anxiety | ☐ Concentration/staying focused |
| Mathematics: ☐ Comprehension of written problems ☐ Mathematical equations | | |

## Other services (please specify)

| |
|---|
| Previous: |
| Current: |
| Waitlist: |

| **Family Doctor** | **Referring Healthcare Provider** |
|---|---|
| First & Last Name | First & Last Name |
| Address | Address |
| Telephone # | Telephone # |

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613.526.7125 | f. 613.526.7126
careclinic@perleyhealth.ca
1750 Russell Rd., Ottawa, ON K1G 5Z6
PerleyHealthCareClinic.ca