New England speech Pathology

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Linda Foskey
Certified Practising
Speech Pathologist

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Background Information for Child

Child's Name	Date of Birth	M F Gender
Yes No *Is your child of Aboriginal or Torres Strait Island descent?*	Yes No *Is a language other than English spoken at home?*	
Parent's/Carer's Name	Parent's/Carer's Name	
Home Phone / Mobile Phone	Home Phone / Mobile Phone	
Address	Address	
City, State, Postcode	City, State, Postcode	
Email	Email	

Education

Education/Early Childhood Setting	Other Education/Early Childhood Setting
Days attending / Work Phone	Days attending / Work Phone

Referral Information

Who suggested Speech Pathology for your child?	Phone Number/Contact details

Reason for Referral

Health Information

Details of previous diagnosis/current concerns (e.g. speech, language, fluency, autism, genetic condition)

GP's Name

Location/Phone Number

Paediatrician's Name

Location/Phone Number

Previous SP Name

Location/Phone

Hearing Test (Date, Result)

Vision Test (Date, result)

Other services/professionals involved

Other Allied Health Name/designation

Current Medications

- ☐ Ear aches / ear infections
- ☐ Coughs / colds
- ☐ Tonsillitis
- ☐ Epilepsy / seizures / fits
- ☐ Headaches
- ☐ Asthma / Bronchial
- ☐ Allergies
- ☐ Infectious diseases (measles, rubella, chicken pox etc)

Check all that apply above and add details

Any other comments?

I give consent for my child to be seen by Linda Foskey Certified Practising Speech Pathologist.

I give consent for Linda Foskey to access information regarding previous speech pathology or medical, dental, academic or other interventions relevant to my child's Speech Pathology treatment.

Parent's/Guardian's Signature

Date

Thank you for taking the time to fill out this questionnaire

Please return it to: Linda Foskey Speech Pathologist PO Box 1228 Inverell 2360