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COMMUNICATION REFERRAL FORM
(Comprehensive Assessment)

IMPORTANT: Please complete all personal information (address, postal code. etc.)

Name:	Date of Birth:
Parents/Guardians:	Age:
Address:	Grade:
Postal Code:	Repeated Grade:
Telephone (home):	School:
Mother's Work #:	Teacher:
Mother's Cell #:	

Please check the areas in which you notice the student is having difficulty:

- articulation
- language (vocabulary, grammar, etc.)
- auditory processing (understanding verbal instructions or questions, memory difficulties, disorganization, word-retrieval difficulties)
- hearing (frequently asks you to repeat things, history of middle ear infections)
- attention
- stuttering
- voice (husky or hoarse, nasal)
- pragmatics (social communication)

Other:

- referred to the Child & Youth Development Clinic
- seen for a Educational Psychologist's Evaluation
- seen for an Occupational Therapy Assessment
- behavioral problems
- chronic health issues: please specify: _____
- academic problems: _____
- physical disabilities: _____
- EAL (English as an Additional Language) – First Language is _____

Additional Comments: _____

NOTE: Signed Parental Consent Form must accompany this referral form.

What are you hoping to gain from this assessment (i.e. areas of language weakness, programming ideas, etc.)? _____

 Referral Source

 Date