**Speech-language therapy assessment referral form**

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| **Name of person to be assessed** |  | **Date of referral** |  |
| **DOB** |  | **Address, phone number / email and names of key family/ whanau**/**carers** (if appropriate) |  |
| **Name of person making the referral** |  | **Referrer’s role, agency and contact information** |  |
| **Has funding been approved for this assessment?** |  | **Please provide funder’s details for quotes/invoicing** |  |
| **Ethnicity**  |  | **Languages spoken / understood** by the person and their family |  |
| **Education provider / employer (if relevant)** |  | **Hearing status** or any concerns about hearing |  |
| **Have any diagnoses been given?** If yes, please provide details. |  |
| **Have they received speech-language therapy before?** If yes, please provide details. |  |
| **Where should assessments take place?** Please provide address and name of person / phone number and email address to contact to arrange appointments |  |
| **Other professionals involved (name, agency, email and phone number)** |
| **Key concerns / issues about this person’s spoken /written communication** (comment as appropriate on expressive language, understanding of what is being said, speech sounds, social communication, stuttering/stammering, voice, reading, spelling, writing and anything else relevant to communication)  |
| Please note any important dates e.g. when the assessment report is needed by, or meetings the SLT needs to attend  |

Please return this form to Talking Trouble Aotearoa NZ by email referrals@talkingtroublenz.org and contact 09 889 8738 with any queries.

**Consent Form for Communication Assessment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have been advised that these speech-language therapy services are to assist me (or the person for whom I can give consent) to find out more about talking and understanding of language. The speech-language therapist may use a range of methods to find out this information such as observation, working on 1:1 assessment tasks, talking to those who know me/this person well, video/audio recording.

**I consent to this assessment taking place........... YES / NO (please circle)**

I am aware that the speech-language therapist may need to liaise with other people who know and support me/this person. For example, doctors, nurses, occupational therapists, psychologists, social workers, audiologists, care staff etc.

**I give my consent for the speech language therapist to liaise with relevant people who know and support me/this person ….....................................YES / NO (please circle)**

I know that the speech-language therapist may need to audio record or video record her conversations with me/this person to help her to gather accurate information about communication. All audio, visual, written information collected will be kept confidential and stored safely.

**I give my consent for the speech language therapist to audio or video record information during their sessions. ....................YES / NO (please circle)**

**I understand that information collected will be confidential and stored safely………… YES / NO (please circle)**

**I am aware that these services do not involve on-going speech and language therapy support once the current funding has run out. ...........YES / NO (please circle)**

Signature of person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person giving consent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_