Cerebral Palsy Alliance Singapore

Cerebral Palsy Centre, 65 Pasir Ris Drive 1, Singapore 519529
Tel: 6585-5600 Fax: 6585-5603

Referral Form

Feeding & Swallowing Clinic

Name of Client: _____**Date of Birth:** _____**Male/Female:**_____

Medical Diagnosis: _____

Parents contact (H/P no.)_____**Preferred time:**_____**(Morning/Afternoon)**

Type of Program enrolled: ☐ Schooler ☐ EIPIC ☐ Out-Patient ☐ DAC/GROW

If Schooler/ EIPIC, Please mention ☐ Academic ☐ Readiness ☐ Functional ☐ High Support

Client is currently receiving services from: ☐ None of the following

- Speech Language Therapist Name/Organisation_____
- Occupational Therapist Name/Organisation_____
- Physiotherapist Name/ Organisation_____

Reason for Referral

(Please briefly describe about the client`s feeding and/or swallowing problem)

_____

_____

_____

Referred by :_____**(Teacher/ EIPIC Interventionist/Parents/Guardian/Training Officer/Nurse/SLP/OT/PT)**

(Please, circle whichever appropriate)

Contact no: _____ **(Teacher)** **Date of referral:** _____