Speech and Language Pathology Department

Feeding & Swallowing Clinic

Referral Form

Name of client: _____ Date of birth: _____

Current Class & Time: _____ Diagnosis: _____

Parent's contact number: _____ **Preferred time:** _____ **(Morning/Afternoon)**

Program: ☐ EIPIC ☐ School ☐ GROW/DAC ☐ Outpatient

Reason(s) for referral:

_____

_____

_____

_____

Referred by: _____

Date of referral: _____

Please return this form to the SLP department.