Cerebral Palsy Alliance Singapore

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

Speech & Language Pathology Department

Audiology Clinic Referral Form

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

Medical Diagnosis: _____

Parents contact (HP No.)_____**Preferred time:**_____**(AM/PM)**

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:

(eg., Complaint of ear pain, ear discharge, unable to follow instruction even with the hearing aids,etc.)

_____

_____

_____

Referred by:_____(**Teacher/ EIPIC Interventionist/Parents/Guardian/Training Officer/Nurse/SLP/OT/PT)**
(Please, circle whichever appropriate)

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