Referral Form - Adult Stuttering/Cluttering Service

Fax # 613-526-7126

Client's Personal Information

First name	Last name	Date of birth (dd/mm/yyyy)	Age	Gender ☐ M ☐ F ☐ Other:
Address Apt. City		Province Postal Code		Preferred Pronouns
Primary phone #	Secondary phone #	Languages spoken ☐ English ☐ French ☐ Other (specify)		
Communicates ☐ verbally ☐ using a communication tool ☐ using gestures ☐ someone responds for him/her				
Mobility: ☐ without assistance ☐ with cane ☐ with walker ☐ wheelchair		Falls in last month: ☐ No ☐Yes If yes, how many?		
Is able to come to the clinic? ☐ No ☐ Yes				
Diagnosis or medical condition(s)		Insurance Coverage: ☐ HCAI ☐ WSIB ☐ Third Party If Third Party, please specify:		
Referral source (How did you hear about the clinic?) ☐ Medical Referral ☐ Online ☐ Word of Mouth ☐ Other:				

Substitute-Decision Maker (if applicable)

First name	Last name	Relationship to client
Telephone # to book appointments		Preferred language ☐ English ☐ French

Reason for Referral

The client shows difficulties with (select all that apply)	
Completing daily activities: ☐ Personal care (hygiene, dressing, meals) ☐ Household tasks/work/volunteering ☐ Hobbies	
Listening and understanding/comprehension: ☐ Following conversation in noisy environments ☐ Feels that others mumble ☐ Following instructions ☐ Experiences buzzing/whistling in the ears	
Speaking: ☐ Difficulty finding words ☐ Change in vocal quality (hoarse/soft voice) ☐ Clarity of speech	
Writing: ☐ Holding a pen ☐ Tremors ☐ Difficulty finding ideas	☐ Reading (understanding written material)
Physical aspects: ☐ Walking ☐ Balance ☐ Strength ☐ Stairs ☐ Return to sport ☐ Getting out of bed or chair ☐ Pain (if so, where? ____________________)	
Other: ☐ Concentration/attention ☐ Retaining information ☐ Swallowing/eating/drinking	

Other Rehabilitation Services (please specify)

Previous:
Current:
Waitlist:

Family Doctor	**Referring Healthcare Provider**
First & Last Name	First & Last Name
Address	Address
Telephone #	Telephone #

Updated Dec 2023