Curtin University

HEALTH AND WELLNESS CENTRE

# Curtin Stuttering Clinic Referral Form

| **Client details** | | | Date: |
|---|---|---|---|
| First Name: | Surname: | | ☐ M or ☐ F |
| Preferred Name: | | DOB: | Age: |
| Parent /Guardian: | | Mobile: | |
| Telephone - Home: | | Work: | |
| Street Address: | | | |
| Suburb: | | Postcode | |
| Email: | | | |
| School: | | Teacher: | |
| What are the client's interests? | | | |

**Referral for** (Please tick)

| | | |
|---|---|---|
| ☐ Assessment | ☐ Individual Treatment Sessions | |
| ☐ Boys and Girls Fluency Group | ☐ Adolescent / Adult Fluency Group | ☐ Downs Syndrome Group |

**Reason for Referral** Age of onset: Is there a family history? ☐ Yes ☐ No

Is there other agency or specialist involvement? ☐ Yes ☐ No

If Yes, by whom?

Describe any previous treatment:

Note: All clients are individually assessed to determine suitability.

**Details of Referrer**

| | | |
|---|---|---|
| First Name: | Surname: | |
| Position: | Service: | |
| Street Address: | | |
| Suburb: | | Postcode: |
| Email: | | |
| Telephone: | Fax: | |
| Signature: | | |

**Fax to (08) 9266 3679** or **Email curtinclinics404@curtin.edu.au**

Contact us on (08) **9266 1717** if you have any enquiries.