ability Therapy Place

STROKE REHABILITATION MOBILE CLINIC. BACK PAIN MANAGEMENT MOBILE CLINIC. SPORTS INJURY CLINIC. PAEDIATRIC NEURAL REHAB. SPEECH THERAPY. PROSTHETICS & ORTHOTICS. ERGONOMIC WORKPLACE ASSESMENT. SUPPLIES OF REHAB AIDS & EQUIPMENT HYDROTHERAPY CLINIC.

SPEECH THERAPY REQUEST FORM

Surname ______________________ Other Names ______________________

Age ______________________ Address ______________________

Referring Doctor ______________________

Date ______________________

SPEECH THERAPY SERVICES

- ☐ Articulation and phonological delay (sound errors)
- ☐ Language delays (expressive and/or receptive)
- ☐ Auditory processing
- ☐ Voice or resonance
- ☐ Dysarthria/apraxia of speech
- ☐ Auditory Processing
- ☐ Cognitive/language delays
- ☐ Pragmatics/social skills
- ☐ Fluency/stuttering
- ☐ Swallowing
- ☐ Difficulties due to aphasia

DIAGNOSIS:

RELEVANT MEDICAL HISTORY:

TREATMENT REQUIRED

DOCTOR'S NAME ______________________ **SIGNATURE** ______________________

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Restoring Health & Function