



**SMALL TALK CENTRE FOR LANGUAGE DEVELOPMENT  
Referral / Application Form**

*Please mail to:* Small Talk Centre for Language Development  
574 West 20th Avenue  
Vancouver, BC, V5Z 1X7

*Or fax to:* 604.872.3912 (Attention: Jennifer Campbell)

*For email enquiries:* Please contact Jennifer Campbell at  
jennifer.smalltalk@telus.net

**Date of referral:** \_\_\_\_\_

**FAMILY AND CHILD INFORMATION:**

**Child's Name:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Child's First Language:** \_\_\_\_\_  
\_\_\_\_\_

**Postal Code:** \_\_\_\_\_ **Proficiency in English:** \_\_\_\_\_  
\_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Family email address:** \_\_\_\_\_

**Please give a brief description of your speech and language concerns regarding this child:**

\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION:**

Has your child been assessed at Sunny Hill or BC Children's Hospital? \_\_\_\_\_

Does your child have a diagnosis of autism? \_\_\_\_\_

Does your child have a diagnosis of a developmental disability? \_\_\_\_\_

Does your child have any other medical diagnosis? \_\_\_\_\_

Is your child on any medication? (please list) \_\_\_\_\_

\_\_\_\_\_

Has your child's hearing been tested? (please give details) \_\_\_\_\_

\_\_\_\_\_

**REFERRAL SOURCE INFORMATION:**

Name of Referring Speech-Language Pathologist: \_\_\_\_\_

Based at: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**CONSENT:**

- I give permission for Small Talk to obtain written and verbal information regarding my child from the referral source.
- I give Small Talk permission to share file information with the Ministry of Children and Family Development as this ministry is a partner in the funding of services for my child.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date

- Assessment documents / reports are attached