Health PEI Santé Î.-P.-É.

Adult Speech and Language Pathology Referral

Name:	**Date of Birth: (D/M/Y)**	**Personal Health Number** (Provincial Health Card):

Home Telephone: **Work Telephone:**

Cell Telephone: Please circle the number we could reach you during the day.

Email:

May we contact you by e-mail: ☐ Yes ☐ No

Address:

Languages Spoken:
☐ English ☐ French ☐ Other:

Guardian/Alternate Contact Info:

Reason for Referral: (Check all that apply)

☐ AAC ☐ Traumatic Brain Injury ☐ Progressive Neurological
Please specify_____

☐ Voice ☐ Stuttering

☐ Other ☐ Gender-affirming voice and communication services
Please specify_____

Other Services Involved: (Check all that apply)

☐ Neurologist ☐ Geriatrician ☐ Respirologist

☐ Ear, Nose, and Throat (ENT) ☐ The Voice Clinic QE 11 Team ☐ Stan Cassidy

☐ Other: _____

Medical information/ Additional comments:

Referred By:_____ Telephone: _____ Date: _____

Address of referral source:_____

Speech Language Pathology Program Contacts	
Charlottetown 161 St. Peters Road PO Box 2000 Charlottetown, PE C1A 7N8	T: 902 368 4437 F: 902 620 3195
Summerside 205 Linden Ave Summerside, PE C1N 2K4	T: 902 888 8160 F: 902 888 8153
Provincial Contact	Toll Free: 1 844 344 8255 speechandhearing@ihis.org

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