



Speech-Language Pathology Client Information & Referral Form

Name:	Date of Birth:	
Parent/Guardian:	Email:	
	Contact Number:	

Please Check Area(s) of Need:

- Mouth Breathing
- Snoring, teeth grinding, TMJD
- Low Tongue Posture
- Feeding
- Thumb Sucking
- Difficulty producing speech sounds clearly (e.g., 's', 'r', 'l')
- Stuttering
- Reading Difficulties

Parent/Patient is aware of this referral and has provided consent for information to be shared
Fee for Service: \$150/hr, \$80/half hour
Located in the Bonnyville Medical Clinic (#101 4610 50 St, Bonnyville, AB

Parent/Patient has consented to dental office sharing the Dentists' findings, recommendations, and treatment plan. If so, please attach information to this referral from.

Please fax form to 1-587-701-5033 to submit referral to Speech-Language Pathologist.

Referring Clinic Contact Information:

Dentist Signature