McMaster Children's Hospital

PHYSICIAN REFERRAL

To: Speech-Language Pathology

Velopharyngeal Inadequacy (VPI) Clinic

H.I.N. x_____

Name: _____ Date of Birth: _____

Address: _____ Phone no.: _____ home

_____ _____ work

postal code

Parent/Guardian Name(s): _____

Medical Diagnosis: _____

_____

Resonance Problem: too much nasality ☐ too little nasality ☐ not sure ☐

Comments : _____

_____

_____

Has this child had a tonsillectomy and/or adenoidectomy?: yes ☐ no ☐ planned in future ☐

Speech Language Pathologist involved ? yes ☐_____ no ☐

(SLP NAME and TELEPHONE NUMBER)

Please forward copies of recent consult notes, if applicable, along with this form to:

VPI Clinic at Hamilton Health Sciences, McMaster Children's Hospital
Attention: Christina Mellies, Chedoke Site - Evel 4 , Box 2000, Hamilton ON L8N 3Z5 OR Fax 905-521-7953

The family will be contacted directly to schedule the assessment once their child's name has come up on the waitlist.

Signature of Referring Physician: X _____

Date of Referral: **X** _____

Name of Referring Physician (***please print clearly***): _____

Address: _____

_____

Phone no.: _____