



To: Speech-Language Pathology
Velopharyngeal Inadequacy (VPI) Clinic

H.I.N. x _____

Name: _____ Date of Birth: _____
Address: _____ Phone no.: _____
home
postal code work

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 Ron Joyce Children's Health Centre Site of McMaster Children's Hospital
Attention: Christina Mellies, Ron Joyce Children's Health Centre, 237 Barton Street East, Hamilton, ON, L8L 2X2 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.: _____