Claire Wylie M.Sc. CCC-SLP

New Referral

Name of Child……**Date of Birth**.....

Name of Parent/Guardian…….

Address……

Daytime Phone Number……**Email**…….

Consent: I ……consent to the release of information to Claire Wylie about my child by the person or agency identified below for the purpose of a consultation and ongoing treatment. I consent to Claire Wylie releasing information to the person or agency identified below where necessary for the ongoing treatment of any communication disorder my child may have.

Signature of parent or guardian……

Referal from (please check):

Parent….

Teacher/Daycare…….Name and contact information……..

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Physician……Name and contact information……..

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Other…..Name and contact information……

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Reason for referral:……

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Please mail or fax referral to: **582 Lefevere Avenue,**
Kelowna, BC, V1W 5G8

Fax: 1-877-2080910