Clinique interprofessionnelle
au Perley Rideau
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613-526-7125

uOttawa

Interprofessional Clinic
at Perley Rideau
icadmin@prvhc.com
613-526-7126

Summer Program for Youth Who Stutter - Registration Form

Program Dates: July 8-12, 2019 - 9:00 a.m. to 3:00 p.m. daily
Location: Interprofessional Clinic at Perley Rideau
1750 Russell Road, Ottawa, Ontario

Referred by: ______________________ ☐ Primary Care Provider ☐ Speech Language Pathologist Billing/License # ______________
Name

Address ____
Street /City/Province/Postal Code

Phone ____________ Fax ____________ ______________________ Date ____________
Signature

Child's Name ______________________ D.O.B. ____________ Age ______ Gender ☐ M ☐ F
dd/mm/yyyy

Address ____
Street /City/Province/Postal Code

Mailing Address ____
(if different than above}

Speech, Language, Fluency and Stuttering Information

Questions 1 to 15 to be completed by the referring speech language pathologist or *primary care provider.

1. What prompted you to register the child for Camp? ______________________

2. Describe the child's speaking difficulty in your own words (please mention all areas of concern) ______________________

3. At what age did the child start stuttering? ______________________

4. How has the child's speech changed since that time? ______________________

5. What seems to help the child when he or she is stuttering? ______________________

6. Has the child ever demonstrated any:

☐ Awareness of stuttering ☐ Physical tension during stuttering
☐ Frustration about speaking ☐ Complaints that s/he "can't talk"

Describe ____

7. Has the child ever been teased about stuttering? ☐ Yes ☐ No

Describe ____

8. Has the child ever discussed his/her speaking difficulties with you? ☐ Yes ☐ No

Describe ______________________________

____

9. Is there any history of stuttering in the family? ______________________________

____

Do any of the child's parents, brothers, or sisters stutter? ______________________________

Anyone on child's mother's side? ______________ Anyone on child's father's side? ______________

Describe the relative(s)' stuttering ______________________________

____

10. How would you rate the child's stuttering at its best and at its worst? Check two boxes below.

Very Mild			Moderate			Very Severe
☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**	☐ **6**	☐ **7**

11. How does the child's stuttering affect his or her:

Academic performance? ______________________________

Participation in school activities? ______________________________

Interaction with other children? ______________________________

Interaction with family members? ______________________________

Willingness to talk and communicate? ______________________________

Self-esteem or attitude toward self? ______________________________

12. Has the child previously been assessed for speech/language concerns? ☐ Yes ☐ No

If so, describe: ______________________________

____

*** If the child is referred by their primary care provider, please include report from speech language pathologist (SLP). If the child has never been assessed by an SLP, you will be contacted by our clinic to book an appointment with the speech language pathologist. Note that the assessment fee is $200.**

13. Has the child received any prior speech/language therapy? ☐ Yes ☐ No

If so, where? ______________ By whom? ______________

For how long? ______________ Focus of treament? ______________

Results of treatment? ______________________________

14. Have any other family members had speech/language problems, other than stuttering? ☐ Yes ☐ No

Indicate the person's relationship to the child and the nature of the problem: ______________

____

15. Please add any information you think is relevant or use this space to elaborate on any of your answers above:

____

____

____

Parent/Legal Guardian Name:	Parent/Legal Guardian Name:
☐ Primary Contact ☐ Secondary Contact	☐ Primary Contact ☐ Secondary Contact
Relationship to Child? ________	Relationship to Child? ________
Home Phone ________	Home Phone ________
Cell Phone ________	Cell Phone ________
Work Phone ________	Work Phone ________
E-mail ________	E-mail ________
What is the best way to contact you?	
☐ Phone ☐ E-mail	☐ Phone ☐ E-mail

Emergency Contact Name ____________________ Phone ____________________

Please submit the completed Registration Form and a $50.00 non-refundable deposit on or before June 8th, 2018.

By mail Interprofessional Clinic at Perley Rideau
The Perley and Rideau Veteran's Health Centre
1750 Russell Road, Ottawa, Ontario
K1G 5Z6

By cheque payable to: **The University of Ottawa Health Services**

By telephone by calling **613-526-7125** : Debit or Credit Card (Visa or MasterCard) accepted

By fax at **613-526-7126**

The $450 remaining balance is due by July 5th, 2019

For any questions regarding the summer program for youth who stutter or services offered at the Interprofessional Clinic, please contact our clinic at 613-526-7125 or by email icadmin@prvhc.com