|  |  |
| --- | --- |
|  **Electronic version****Intellectual disability, autism spectrum disorder and physical disability programs** | Services requestStuttering**PROFESSIONAL'S SECTION** |
| **MUST BE FILLED OUT BY A DOCTOR OR SPEECH THERAPIST** |

|  |  |
| --- | --- |
| 1. **Child identification**
 |  |
| LAST NAME      | FIRST NAME      | DATE OF BIRTH      |
| Mother's or parent's e-mail 1 :       |
| Father's or parent's e-mail 2:       |

|  |  |
| --- | --- |
| 1. **Eligibility for stuttering services**
 |  |
| The child has been stuttering for more than 6 months: | [ ]  Yes [ ]  No |
| The child is between 3 and 17 years old  | [ ]  Yes [ ]  No |
| The child lives in Laval: | [ ]  Yes [ ]  No |
| The completed Accueil-Analyse-Orientation-Référence (AAOR) reference form is attached to this request. | [ ]  Yes [ ]  No |
| *\* The professional must have answered “yes” to all of the questions above for this request to be eligible and complete. The AAOR form is available on the website www.lavalensanté.com* |

|  |  |
| --- | --- |
| 1. **Family background**
 |  |
| Do you have family members, close or distant … |
| Who once stuttered, but no longer do? | [ ]  Yes[ ]  No | If yes, which ones?       |
| Who have stuttered before and still do? | [ ]  Yes[ ]  No | If yes, which ones?       |
| Who had language difficulties? | [ ]  Yes[ ]  No | If yes, which ones?       |

|  |  |
| --- | --- |
| 1. **General informations**
 |  |
| In what language does the child communicate with his or her parents? |       |
| In what language does the child communicate at school/daycare? |       |
| Is the child awaiting diagnostic evaluation or has he or she already received a diagnosis?  | [ ]  Yes [ ]  No |
| If yes, specify:       |
| If the child goes to school, does he or she present with learning difficulty/impairment? | [ ]  Yes [ ]  No |
| If yes, please give details:       |
|  |
| 1. **Flow**
 |  |
| At what age was the child's stuttering first noticed?      |
| Are there any changes in your child’s stuttering since it first appeared?[ ]  Yes [ ]  No If no, please give details :       |
| Is the child's stuttering: [ ]  Constant [ ]  Variable (good and bad times) |
| What are the most significant impacts of stuttering on the child today?      |
| Does the child seem to be forcing or pushing out the words when speaking? | [ ]  Yes [ ]  No |
| During a moment of stuttering, do you notice any grimaces, body movements, head movements, eye movements, changes in his/her voice, etc.:[ ]  Yes [ ]  NoIf yes, please give details:       |
| On a scale for 0 to 9, how would you judge the severity of your child’s stuttering?0 = no stuttering1 = Very mild stuttering9 = extremely severe stuttering[ ]  0 [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No stuttering | Very mild |  |  |  | Moderate |  |  |  | Very severe |

 |

|  |  |
| --- | --- |
| **Professional who filled out the form** |  |
| LAST, FIRST NAME      | OCCUPATION[ ]  Doctor [ ]  Speech therapist |
| ESTABLISHMENT / PROGRAM      | ADRESS      |