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

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| 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: | | | |

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| 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* | |

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| 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? |

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| 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: | | | |
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| 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  No  If yes, please give details: | | | |
| On a scale for 0 to 9, how would you judge the severity of your child’s stuttering?  0 = no stuttering  1 = Very mild stuttering  9 = extremely severe stuttering  0  1  2  3  4  5  6  7  8  9   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | No stuttering | Very mild |  |  |  | Moderate |  |  |  | Very severe | | | | |

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