REGISTRATION FORM

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| **PATIENT’S IDENTIFICATION**  |
| Name:  |       |  |
| Date of birth: (DD/MM/YYYY):  |       |  |
| RAMQ no.:  |       | Expiry date (MM/YY): |       |
| Address:  |       |
| Language spoken: |       |  |
| Home telephone: |       |  |
| Work telephone:  |       |  |

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| MEDICAL INFORMATION | SPEECH PROBLEM |
| Diagnosis: |       | [ ]  Aphonia |
| Head and neck cancer : | yes [ ]  | no [ ]  | [ ]  Dysphonia |
| Surgery (including tracheotomy)  | yes [ ]  | no [ ]  | [ ]  Articulation disorder |
| Type:  |       | [ ]  Resonance disorder |
| Date of surgery: | Cliquez ici pour entrer une date. | Another disability that could alter communication abilities: |
| Presence of tracheotomy:  | yes [ ]  | no [ ]  |       |
| Reason for the tracheotomy: |       |
| Surgeon:  |       | Eligible for another program? | yes [ ]  | no [ ]  |
| Hospital:  |       | If yes, specify: |       |
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| Referring professional (name and title): |       |
| Workplace:  |       |
| Telephone:  |       |
| Signature of the referring professional:  |       |
| Date:  | Cliquez ici pour entrer une date. |  |