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. | | |  | |