ASU SPEECH AND HEARING CENTER
P.O. BOX 910, STATE UNIVERSITY, AR 72467-0910
PH. (870) 972-3301 FAX (870) 972-3788

REFERRAL - HEAD AND NECK CANCER PROGRAM

Date: _____ File #: _____

Client: _____ Date of Birth: _____ Age: _____ Sex: _____

Parents/Guardian: _____ Called in by: _____

Address: _____ Referred by: _____

Home Phone: _____ Work phone: _____

Cell #: _____ Email: _____

Type/Stage of Cancer: _____

Location of Cancer: _____

TREATMENT:

Surgery: Y / N If yes, when:_____

Chemotherapy: Y / N If yes, how many treatments: _____ When: _____

Radiation therapy: Y / N If yes, how many treatments: _____ When: _____

Oral eater: Y / N

Peg tube: Y/ N

Voice prosthetic: Y / N If yes, what type: _____

HAVE YOU EVER TESTED POSITIVE FOR TB? (Circle one) YES NO

FOR OFFICE USE

Form completed by:_____

ASSIGNMENT:
SUPERVISOR: _____

CLINICIAN: _____

DAY/TIME: _____ ROOM: _____

ARKANSAS STATE UNIVERSITY

PF

PRESENTING COMPLAINT:

_____

_____

_____

_____

MEDICAL HISTORY:

_____

_____

_____

_____

_____

CONTACT RECORD:

_____

_____

_____

_____