**Paediatric Speech and Language Therapy**

**REFERRAL FORM**

**Early Years Community and Clinic**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name:**Click here to enter text. | **Surname:**Click here to enter text. | | **DOB:**Click here to enter a date. |
| **Address:**Click here to enter text. | | | |
| **Contact Telephone number:** Click here to enter text. | | **Parents/Carer name/s:**Click here to enter text. | |
| **School/Nursery:**Click here to enter text. | | **GP surgery:**Click here to enter text. | |
| **Name of Referrer:**Click here to enter text. | | **Contact details of referrer:** Click here to enter text. | |

*REFERRALS WILL ONLY BE ACCEPTED IF* ***ALL*** *SECTIONS ARE COMPLETED*

***PARENTAL CONSENT MUST BE OBTAINED FOR REFERRALS TO BE ACCEPTED***

***Written or verbal (please indicate below)***

**CONSENT**

|  |  |  |
| --- | --- | --- |
| **I agree to my child being referred for speech and language therapy assessment** | | |
| Parent’s Signature: Click here to enter text. | | Date:Click here to enter a date. |
| Parent’s Name: Click here to enter text. *(please print)* | | |
| Referrer’s Signature: Click here to enter text. | | Date:Click here to enter a date. |
| Referrer’s Name:Click here to enter text. | Profession:Click here to enter text. | |

**BACKGROUND INFORMATION**

**1. Language Background:**

\*What languages are spoken at home? Click here to enter text.

\*What is the child’s strongest language for their speaking and/or understanding? Click here to enter text.

***Is an Interpreter required?***  no  yes 🡪 Choose an item.

**2. Does the child have any (please tick, if yes)**

known hearing difficulties, if yes, please state: Click here to enter text.

known vision difficulties, if yes, please state: Click here to enter text.

medical diagnosis, if yes, please state: Click here to enter text.

learning difficulties, if yes, please state: Click here to enter text.

emotional or behavioural difficulty, if yes, please state: Click here to enter text.

other difficulties, if yes please state: Click here to enter text.

**3. Have any of the following professionals been involved?**

*(Please send us copies of any reports if available)*

|  |  |  |
| --- | --- | --- |
|  | **Name** | Type of Support |
| Educational Psychologist | Click here to enter text. | Click here to enter text. |
| Paediatrician | Click here to enter text. | Click here to enter text. |
| Child & Adolescent Mental Health Services | Click here to enter text. | Click here to enter text. |
| Physiotherapist / Occupational Therapist | Click here to enter text. | Click here to enter text. |
| Other (e.g. Portage, dietician, ENP, WAAS..) | Click here to enter text. | Click here to enter text. |

**4. Has the child seen a Speech & Language Therapist before?**

yes  no

If yes, please give any details: Click here to enter text.

**5. EHCP:**

Yes  No  Considering application

**REFERRAL INFORMATION**

Use the following checklists to indicate the concerns that you have. Please add any information you feel would be useful.

Reason for referral: (*please summarise your main concerns regarding the student’s speech, language and communication)*

Click here to enter text.

1. **Attention and Listening**

Are you concerned?

Yes (complete checklist below)  no (move to section 2)

Please tick if you are concerned and comment below.

Length of time focused on a task

Level of distraction

Response to name

**Comments and Examples:** Click here to enter text.

1. **Understanding**

Are you concerned?

Yes (complete checklist below)  no (move to section 3)

Please tick if you are concerned and comment below.

Ability to follow simple instructions/respond to questions

Frequently needs repetition or gesture to support understanding

Asking for help if they have not understood

**Comments and Examples:** Click here to enter text.

\*Do you have the same worries about the child’s understanding in their home language too?

Yes  No

**Comments and Examples:** Click here to enter text.

1. **Expressive Language Skills**

Are you concerned?

Yes (complete checklist below)  no (move to section 4)

Please tick if you are concerned and comment below.

Ability to use language for a range of purposes in daily life

Ability to use words and sentences at a similar level to other children of the same age

Ability to express their needs verbally

Copies words and phrases that you or others use (e.g. from youtube)

**Comments and Examples:** Click here to enter text.

\*Do you have the same worries about the child’s talking in their home language too?

Yes  No

**Comments and Examples:** Click here to enter text.

1. **Social Skills /Play/Social Use of Language**

Are you concerned?

Yes (complete checklist below)  no (move to section 5)

Please tick if you are concerned and comment below.

Eye contact

Ability to point and use other gestures

Initiating with others (eg. asking you to join in play, showing others what they are doing)

Playing with other children

Taking turns in play / conversations

**Comments and Examples:** Click here to enter text.

1. **Speech Sounds / Voice / Stammer**

Are you concerned?

yes (complete checklist below)  no

Please tick if you are concerned and comment below.

Able to be understood by others

Ability to pronounce specific sounds

Awareness of difficulties speaking

Voice quality habitually hoarse or unusual

Stammer – if yes how long for? Click here to enter text.

**Comments and Examples:** Click here to enter text.

\*Do you have the same worries about the child’s speech in their home language too?

Yes  No

**Comments and Examples:** Click here to enter text.

\* These fields are mandatory.

Please send completed form to [CommPaedSLTReferral@stgeorges.nhs.uk](mailto:CommPaedSLTReferral@stgeorges.nhs.uk)

Tel: 020 8725 8042