**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

Tel: 020 8725 8042