**Children’s Speech and Language Therapy Service Referral Form**

**Mainstream Schools Service**

**Telephone:** 0300 1310 111 **Email:** [provide.ccc@nhs.net](mailto:provide.ccc@nhs.net)

Note: Provide services work to NHS Health and Social Care Information Centre (HSCIC) policies and can only send responses including patient identifiable details (PID) to email addresses that are approved by them. If you are not using an approved email address this may limit the response we can make by email.

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| Date of referral: | NHS number: | |
| **Patient Details** | | |
| Forename: | | Surname: |
| Address and postcode: | | |
| Date of birth: | | Gender: |
| Home telephone: | | Mobile telephone: |
| Allergies: | | Ethnicity: |

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|  | Learning disability |  | Physical impairment | | |  | Sensory impairment |
|  | Mental health condition |  | Longstanding illness | | |  | Other |
| Additional Information: | | | | | | | |
| **GP Details** | | | | | | | |
| Registered GP: | | | | | Telephone: | | |
| GP Practice or F Code: | | | | | | | |
| **School Details** | | | | | | | |
| School address: | | | | Telephone number: | | | |
| Name of leader/teacher: | | | | Name of SENCO: | | | |

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| Others involved: | |
| **Previous contact with service** | |
| **Has this child had contact with speech and language therapy before?** | **IF ‘YES’** - IF THE CHILD WAS DISCHARGED WITHIN LAST 12 MONTHS (please outline what has changed since the child was discharged). |

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| **Family information** | |
| Name of parents/carers: |  |
| Names of other adults living at the child’s address: |  |
| Names and DOB of siblings: |  |
| Other: |  |

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| **Languages spoken at home:** (please complete) |
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| **Family history of:** | **Please state family member:** |
| Late talking: |  |
| Unclear speech: |  |
| Stammering: |  |
| Slow learning/difficulties in school: |  |

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| **Medical history** | |
| Eczema/ asthma/ ear infections/ tonsillitis: |  |
| Hospitalisations/ major illnesses: |  |
| Other medical conditions: |  |

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| **Date and result of last hearing test** | | | | |
| History of hearing loss (please tick **✓**): |  | Yes |  | No |

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| **Description of speech and language** (please tick **✓** all that apply): | | | |
| Poor attention / Listening |  | Difficulty following Instructions |  |
| Difficulty linking words |  | Limited vocabulary |  |
| Unclear speech sounds |  | No useful speech |  |
| Stammer |  | Unintelligible to family/outside family |  |
| Social communication |  |  | |

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|  | Parents/carers | | | | | Referrer | | | | |
| **Level of concern** | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Scale 1-5 (1 = low, 5 = high)  Please tick |  |  |  |  |  |  |  |  |  |  |

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| **Other information** |
| Child protection status: |

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| **National Curriculum levels/P scale levels/Foundation stage profile levels** |
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| **Referrer details** (complete if not patient’s GP) |  | Tick **✓** if patient’s GP |
| Name: | Job role: | |
| Organisation\service: | Telephone number: | |

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| **Consent** | | | | | | | |
| Please give date of consent to this referral: | | |  | | | | |
| Name of person giving consent: | | |  | | | | |
| Signature of person giving consent: | | |  | | | | |
| Role: (please tick **✓**) |  | Parent | |  | Carer |  | Social Worker |

**Notes**

* Please ensure that this form is completed fully, preferably with parent/carer, as incomplete forms will not be accepted.
* **Our referral criteria for children in year one and above require evidence that school is needing to support child’s speech, language or communication (old School Action Plus/One Plan) and for the Speech and Language Audit Tool (SPLAT) Speech and Language Screen (p 24-6) to be completed by school.**
* **Referrals will be delayed until evidence of school support and Speech and Language Screen have been received.**
* **Please return to Provide, Care Co-ordination Centre, SLT Service, Colchester Business Park, 900 The Crescent, Colchester, CO4 9YQ.**
* **Please use tracked post.**