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

**Pre-School Service**

**Telephone:** 0300 1310 111 **Email:** provide.ccc@nhs.net

Note: Provide services work to NHS Connecting for Health 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: | | | |
|  | 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** | | | | | | | | | | |
| Pre-school/nursery address: | | | | | Telephone number: | | | | | |
| Name of leader/teacher: | | | | | Name of SENCO: | | | | | |

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| **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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| **Significant birth history:** (please detail) |
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|  | **Please tick ✓** | | | |
| **Developmental milestones** |  | Age appropriate |  | Delayed |
| Dummy/bottle |  | Yes |  | No |
| Evidence of symbolic play |  | Yes |  | No |

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

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| **Speech and Language Development – Please indicate age of:** | | | | | |
|  | Babble |  | First real words |  | Simple phrases |

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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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| **Referrer details** (complete if not patient’s GP) |  | Tick if patient’s GP |
| Name: | Job role: | |
| Organisation\service: | Telephone number: | |
| Sender address: | | |

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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 |

Please ensure that this form is completed fully preferably with parent/carer.

Incomplete forms will not be accepted.

**Please return to:** Provide, Care Co-ordination Centre, SLT Service, Colchester Business Park, 900 The Crescent, Colchester, CO4 9YQ or [provide.cccpaediatrics@nhs.net](mailto:provide.cccpaediatrics@nhs.net)