**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.

**Part 1 - Telephone Advice Contact Section**

**Date of discussion:**  **SLT spoken to:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Child’s Name:       DOB:  NHS Number:  School:       SENCo:  Child’s Year Group:  Presenting concerns:  Interventions currently in place/previously tried:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Elklan | Colourful Semantics/ Shape Coding | Visual Supports | Word Aware | Other: |   Is Learning Assistant Support Available for this child? **Yes  No**  Summary of One Plan targets over 2 terms:  Does this child have an EHCP? **Yes**  **No**  Other professionals involved in the care of this child? **Yes  No**  Is this child a Child in Need/Looked after Child/Subject to a Child Protection Plan (please indicate  as relevant) **Yes  No**  New referral orre-referral?   |  |  |  | | --- | --- | --- | | **Parent / Guardian consent** | | | | **I agree to the sharing of information with services relevant to my child’s treatment / care** | | | | **Name of parent/guardian** with parental responsibility *(PRINT NAME)*: | **Signature:**  **If unsigned, verbal consent given:** | **Date:** | |
| **Advice given to SENCo:** |
| **Next Steps:** (tick as appropriate)  **No referral.** Repeat Telephone Advice process in 1 term if concerns remain. Please include evidence that advice given previously has been completed.  **Full referral** to be completed and submitted by SENCo using the process on website |

**Part 2 – Referral Form (SENCo must have completed discussion via advice line above before completing this section. Please complete this with parent/guardian).**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of referral: | | | NHS number: | |
| **Patient Details** | | | | |
| Forename: | | | | Surname: |
| Address and postcode: | | | | |
| Date of birth: | | | | Gender: |
| Home telephone: | | | | Mobile telephone: |
| Allergies: | | | | Ethnicity: |
| **Names of parents/guardians** | | | | |
|  | | | | |
| Home tel: | | Mobile tel: | | |
| Languages spoken at home: | | Interpreter/Signer required: **Yes  No**  Language: | | |
| GP name: | | Health Visitor/School Nurse Name: | | |
| Surgery: | | Base address: | | |
| School name: | | Days/Times attended: | | |
| Address: | | Tel: | | |
| Transport assistance required:  **Yes  No** | Details: | | | |

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|  | Learning disability |  | Physical impairment |  | Sensory impairment |
|  | Mental health condition |  | Longstanding illness |  | Other |
| Diagnosis (if know):  Additional Information: | | | | | |
| Others involved: | | | | | |

|  |  |
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| **Previous contact with service** | |
| **Has this child had contact with speech and language therapy before?**  **Yes  No** | **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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| --- | --- |
| **Medical history** | |
| Eczema/ asthma/ ear infections/ tonsillitis: |  |
| Hospitalisations/ major illnesses: |  |
| Other medical conditions: |  |

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| **General Development** | |
| Has the child had any delay in their general development? | **Yes  No** |
| Is the child known to other professionals in relation to their learning/general development? | **Yes  No** |
| If yes, which professionals? |  |

|  |  |
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| **Hearing/Vision** | |
| Does anyone in the family have a hearing impairment/loss/deafness? | **Yes  No** |
| Has the child had middle ear infections/glue ear? | **Yes  No** |
| Does anyone in the family have visual impairment? | **Yes  No** |

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| **Play and attention** | | |
| What types of games/toys/activities does the child enjoy? | |  |
| Does the child like to play with others (adults or children)? | | **Yes  No** |
| How would you describe the child’s attention span for: | | |
| * Activities of their own choice: |  | |
| * Activities that the parent chooses: |  | |

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| **Speech and Language** | | | | | | |
| Is there a family history of speech and language difficulties? e.g. late talking, unclear talking, stammering, slow learning (please give details of who and what)? | | | | | | |
| Did the child babble as a baby? | | **Yes  No** | | | | |
| At what age did the child: | Say their 1st word: |  | Begin to put 2 words together: |  | Talk in sentences: |  |

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| **Reason for referral:**  (Add details and include latest One Plan/document as relevant with this referral)    **Description of current speech and language** (please tick **✓** all that apply including examples): | | | | |
| **Poor attention / Listening** |  |  | **Difficulty following Instructions** |  |
| **Difficulty linking words** *(e.g. may not use many action words, cannot link words to explain their ideas, in an older child cannot link sentences)* |  |  | **Limited vocabulary** *(e.g. finds is hard to retain and retrieve words they want to talk about)* |  |
| **Unclear speech sounds** (*e.g. misses sounds off words, changing vowel sounds, changes a wide range of sounds)* |  |  | **No useful speech** *(e.g. uses pointing, gesture, reaching consistently to communicate)* |  |
| **Stammer** *(please indicate the impact this has on the child)* |  |  | **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: |

|  |
| --- |
| **Academic skills levels** (e.g. National Curriculum levels/P scale levels/Foundation stage profile): |
|  |

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

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| **Parent / Guardian consent** | | |
| **This referral has been discussed with me, and I agree to take my child to the clinic for assessment and ongoing therapy intervention as required, which may take place in school, clinic or nursery setting.**  **I understand that if I do not attend the assessment, my child will be discharged and no further appointments will be offered. I am aware that for training purposes, a student may be present.**  **I agree to the sharing of information with services relevant to my child’s treatment / care** | | |
| **Name of parent/guardian** with parental responsibility *(PRINT NAME)*: | **Signature:**  **If unsigned, verbal consent given:** | **Date:** |

**Notes**

* Please ensure that this form is completed fully, preferably with parent/carer, as incomplete forms will not be accepted.
* **Please send your form via e-mail to:** [provide.ccc@nhs.net](mailto:provide.ccc@nhs.net)