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

***Notes:***

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.

**Please complete this form in full with parent/carer whose signature must be included at the bottom of the form. Incomplete forms will not be accepted and the referral will be returned. Please send your completed form via e-mail to** [**provide.ccc@nhs.net**](mailto:provide.ccc@nhs.net)

|  |  |
| --- | --- |
| **Referrer’s Details** | |
| Name: | Date: |

|  |  |  |
| --- | --- | --- |
| **Patient Details** | | |
| Forename: | | Surname: |
| Address and postcode: | | |
| Home telephone: | | Gender: |
| Allergies: | | Mobile telephone: |
| Ethnicity: |
| DOB: |
| Is this child a Child in Need/Looked after Child/Subject to a Child Protection Plan  (please indicate as relevant) **Yes  No** | | |
| **Family and Professionals Information** | | |
| Names of parents/guardians: | | |
| Languages spoken at home: | Interpreter/Signer required: **Yes  No**  Language: | |
| GP name: | Teacher name and email: | |
| Surgery: | Class name: | |
| School name and address: | Tel: | |
| SENCO/ Phase lead name and email: | | |
| Names of other professionals 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 24 MONTHS (please outline what has changed since the child was discharged).    If the child has been seen by SLT services other than Provide CIC please include their contact details and recent report. |

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| **Communication needs** |
| What are the child’s EHCP communication targets? |
| How are these communication targets being supported? |
| **Reason for referral request:**  (NB if the child needs dysphagia referral as well please use our dysphagia referral form to request this) |
| **Expected outcome:** |

|  |  |  |
| --- | --- | --- |
| **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** | | |
| **I am aware that the speech and language therapist may discuss my child's referral with the teacher/SENCO/Phase lead before assessment is offered. If the referral is accepted I understand that my child will be seen in the school setting.**  **I am aware that for training purposes, a student may be present for appointments with my child.**  **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:** |

**Please send your completed form via e-mail to** [**provide.ccc@nhs.net**](mailto:provide.ccc@nhs.net)