2022

**Paediatric Speech and Language Therapy Referral Form – Under 5 years**

**Please fill in all sections of this referral form. If these are not filled in the referral will be rejected from the service for insufficient information provided.**

Return via email to wchc.childrenssaltteam@nhs.net or via SystmOne.

We cannot accept referral without consent from person with Parental Responsibility

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| **Section 1 - Parents.*****Personal Details*****Child’s Name: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date of Birth: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHS No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Telephone Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****School/Setting attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Parent/Carer name/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Who has parental responsibility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Is the child currently a family member of the armed forces, reservist or veteran? Yes  No **  |
| **Section 2** ***Other Professionals Involved*****GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Are there any safeguarding issues? Yes 🞏 No 🞏** **If yes, what provision is currently in place for this, e.g. LAC, Child and Family, Child Protection, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Social worker’s name, base and contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Professional:** | **If involved, tick** | **Provide details (including name, contact no, etc.):** |
| **Community Paediatrician** |  |  |
| **Audiology** |  |  |
| **Physiotherapist**  |  |  |
| **Portage** |  |  |
| **Early Years Intervention Team** |  |  |
| **Educational Psychologist** |  |  |
| **Occupational therapist** |  |  |
| **Any private providers** |  |  |
| **Other** |  |  |

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| ***Reason for Referral*****Please comment on the child’s ability in all the sections below if there are concerns.**

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| **Attention and Listening skills (in 1:1 and group settings):**Is this an area of concern? Yes 🞏 No 🞏 |
| **Comprehension (understanding of what people say):**Is this an area of concern? Yes 🞏 No 🞏  |
| **Expressive Language (sentences/grammar):**Is this an area of concern? Yes 🞏 No 🞏  |
| **Speech sounds (articulation/pronunciation):**Is this an area of concern? Yes 🞏 No 🞏 |
| **Social Communication Skills (interactions with others):**Is this an area of concern?**Yes 🞏 No 🞏**  If yes, please provide details below. |
| **Fluency of speech (stammering)**Is this an area of concern?Yes 🞏 No 🞏 |
| **Any other information:** |
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| ***Previous SLT/Audiology input*****Has the child ever been referred to/seen by a Speech & Language before: Yes 🞏 No 🞏** **If yes, state when and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****What was the outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Has the child’s hearing been assessed (excluding birth check?) Yes 🞏 No 🞏** **If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ What were the results?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Communication****Does the child use other methods of communication e.g. signing, gesture?** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Is English an additional language Yes 🞏 No 🞏****Would an interpreter be required? Yes 🞏 No 🞏****If yes, what is language and language level like in first language?****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| ***Educational Information*****Does the child have an Education Health Care Plan? Yes 🞏 No 🞏** **If yes, provide EHCP Co-ordinator’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Does the child have an Additional Support Plan? Yes 🞏 No 🞏** **If yes, give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Does the child receive any other additional support in school? Yes 🞏 No 🞏** **If yes, give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Pre-referral Screening required – refer to referral guide and booklet** |
| WellComm screen carried out | Yes 🞏 | No 🞏Please see referral guide before submitting your referral  |
| WellComm score sheets attached to referral | Yes 🞏 | No 🞏 Please see referral guide before submitting your referral  |
| WellComm intervention currently provided including frequency of input: |
| Phonology Screen Carried Out | Yes 🞏 | No 🞏 |
| Sounds and Listening Programme Completed? | Yes 🞏 No 🞏 | Date: |
| ***Parental/Carer Consent*****I agree that this information about my child can be discussed / referred to a Speech & Language Therapist for advice** Yes 🞏 No 🞏**I consent to the Speech and Language Therapy service sending text message and email reminders for appointments** Yes 🞏 No 🞏 **Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****If your child is school age and attends a Local Authority school they will usually be seen in their usual school setting. If this is not appropriate please let us know why:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| ***Referrer Information*****Name of referrer (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Organisation­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| ***Please return Speech and Language Therapy Department*****Via post:** Children’s Speech & Language Therapy, Highfield Centre, Victoria Central Health Centre, Mill Lane, Wallasey, Wirral, CH44 5UF **Via email:** wchc.childrenssaltteam@nhs.net ***If you have any enquiries, please call our office on 0151 514 2334*** |