**PAEDIATRIC SPEECH & LANGUAGE THERAPY**

***(For office use only)***

*Date referral received:*

**SCHOOL AGE REFERRAL FORM**

**PLEASE NOTE THAT WE REQUIRE PARENT/ CARER CONSENT FOR THE REFERRAL & SHARING OF RELEVANT INFORMATION TO HAVE BEEN DISCUSSED AND OBTAINED PRIOR TO COMPLETION OF THIS FORM. WE ARE UNABLE TO SEE CHILDREN WITHOUT THIS.**

**Information Governance**

This form **MUST NOT** be forwarded to Speech & Language by email as it contains confidential /sensitive Information.

**To be faxed only.**

|  |  |  |
| --- | --- | --- |
| 1. **Parent / Carer consent gained for:**
 | YES | NO |
| Referral to the Speech and Language Therapy Service (and to assessment and treatment if appropriate) | [ ]  | [ ]  |
| Sharing of records with other health & education professionals: | [ ]  | [ ]  |
| Receive SMS text appointments:  | [ ]  | [ ]  |

Parent/ Carer signature: ……………………………….…………………… Date: ……………………...………

1. **Child’s Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Forename: | <Patient Name> | Surname: | <Patient Name> |
| Date of Birth: | <Date of birth> | Gender: | <Gender> |
| Address: | <Patient Address> |
| Postcode: | <Patient Address> | NHS Number (if known): | <NHS number> |
| Telephone No: | <Patient Contact Details> | Mobile: | <Patient Contact Details> |
| Patient Access Information Requirement: | <Diagnoses> |
| GP Name: | <GP Name> | GP Practice: | <GP Details> |
| Child’s Main Language: | <Main spoken language> | Child’s other language/s: |       |
| Ethnic Origin: | <Ethnicity> | Religion: | <Religion> |
| Medical Diagnosis: |       |

1. **Parent/ Family Details:**

|  |  |
| --- | --- |
| Parent Name/s: |       |
| Parent’s Main Language: |       | Dialect: |       |
| Does the **parent** require an interpreter: | YES [ ]  NO [ ]  | Does the **child** require an interpreter: | YES [ ]  NO [ ]  | Preferred gender of interpreter: | <Gender>Either [ ]  |
| Family history of Speech & Language difficulties (please state relationship to child & diagnosis): | <Family History>      | Name of Therapist who saw sibling: |       |

|  |  |  |
| --- | --- | --- |
| 1. **Safeguarding:**
 | YES | NO |
| I am aware of safeguarding concerns regarding this child:  | [ ]  | [ ]  |
| Child Protection Plan :  | [ ]  | [ ]  |
| Common Assessment Framework:  | [ ]  | [ ]  |
| Please state the named contact: |       | Contact No or E-mail: |       |

1. **School Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| School Name | <Patient School> | Key contact in setting (include name and role): |       |
| School Address: |       |
| Postcode: |       | Telephone No: |       |
| School Nurse: |       | SN Base: |       |
| Does your setting commission a Speech & Language Therapist?  | YES [ ]  NO [ ]  If yes, SLT Name:       SLT Contact No:       |

1. **Other professionals:** Please state contact name & number/ e- mail of other Health/ Education Professionals involved

|  |  |  |  |
| --- | --- | --- | --- |
| **PROFESSIONAL** | **CONTACT DETAILS:** **(Name & Number/ email)** | **PROFESSIONAL** | **CONTACT DETAILS:****(Name & Number/ email)** |
| Educational Psychology  |       | Families First  |       |
| CAMHS |       | Child & Family Services |       |
| Occupational Therapy |       | Physiotherapy |       |
| Paediatrician |       | Cognition & Learning Team |       |
| Audiology |       | Other (please state) |       |
| Please state the outcome of referrals to these services: |       |
| Do you have concerns regarding the child’s hearing?  | Yes [ ]  No [ ]  | If yes, has a referral to audiology been made?  | Yes [ ]  No [ ]  |

**REFERRALS FOR SCHOOL AGE CHILDREN COMPLETED BY SETTINGS WILL ONLY BE ACCEPTED WHEN THE ABOVE INFORMATION IS ACCOMPANIED BY OTHER RELEVANT INFORMATION E.G. IEP’S & REPORTS FROM EDUCATION PROFESSIONALS Are copies of relevant reports attached: Yes** [ ]  **No** [ ]

1. **Reason/s for referral:**

*Please describe your concerns regarding the child’s speech and language development:*

* **Speech:** clarity of speech, pronunciation of sounds, articulation, substitution of sounds, missing sounds
* **Understanding of Language:** ability to follow routines, instructions, questions, understanding of words
* **Use of Language**: words used, vocabulary, sentence length, grammar, use of gesture
* **Social Interaction:** interaction with peers, interaction with adults, eye contact, turn taking, appropriacy of language
* **Stammer/ Stutter**: repeating parts of words e.g. ‘c..c..c..can’, ‘stretching parts of words e.g. ‘ssssock’, child tries to talk but no sound comes out at all, extra body movements/ tension e.g. stamping feet, child/parental anxiety, avoidance of speaking e.g. situations or words. \*If a child is only repeating words/ phrases this is not stammering but could be linked to EAL or language processing difficulties. Please refer for expressive language assessment.
* **Eating/ drinking/ swallowing**

|  |  |
| --- | --- |
| Please give details/ examples of the child’s difficulties : |       |
| What is the impact of the child’s difficulty on the child; self-esteem, avoidance, friendships/ family; anxiety/ setting; inclusion, attainment (please describe): |       |
| What would you like to happen as a result of this referral (please describe e.g. increased participation from the child, to improve the well-being of the child, to raise staff’s awareness of the child’s difficulties, support for parents, advice and strategies to support the child’s development etc):  |       |

**PLEASE NOTE THAT INSUFFICIENT REFERRAL INFORMATION MAY DELAY THE REFERRAL PROCESS**

1. **Details of the referrer:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer’s Name | <Sender Name> | Designation: | <Sender Details> |
| Referrer’s Address: | <Sender Address> |
| Postcode: | <Sender Address> | Telephone No: | <Sender Details> |

Signed: ………………………………................................................. Date: <Specific Referral Out Details>

**THIS FORM WILL BE RETURNED TO THE REFERRER IF IT IS NOT FULLY COMPLETED WITH THE NECESSARY DOCUMENTS ATTACHED.**

1. **Information from School:**

|  |  |  |
| --- | --- | --- |
| What category of provision is the child’s **primary** need: | Speech, language & communication | [ ]  |
| Hearing impairment | [ ]  |
| Autism, communication & interaction | [ ]  |
| Cognition & learning | [ ]  |
| What range of provision does the child access at present? |  [ ]  Range 1 [ ]  Range 2 [ ]  Range 3 [ ]  Range 4 |
| Can school designate a staff member to complete 1:1/ small group work with the child? |  Yes [ ]  No [ ]  Name of staff member: …………………………………………  |
| School - Please provide information regarding the child’s current levels and rate of progress:  |       |
| Please describe how the child meets the criteria for Range 2 or 3 provisions in school (please refer to the SEND guidance 2014):  |       |
| Please describe the child’s strengths & weaknesses:  |       |
| Current actions/ interventions in place to meet the child’s needs (please describe: IEP, strategies used; small group work etc.) & what have been the outcomes of these interventions:  |       |

**PLEASE RETURN TO:**

Bradford District Care NHS Foundation Trust

Bradford Speech and Language Service

Fax: 01274 215660

Bradford

BD7 3EG

770397