Request for the Involvement of The Children's Speech & Language Therapy Service – Communication (updated November 2020)

Child's First Name(s):…….. **Surname:** ……

NHS Number:..... **Sex**: Male ☐ / Female ☐

Date of Birth: ……..…. **Age:** ……

Address: ……

…….. **Postcode**: ……

Named Carer(s):…….. **Telephone**: ……

Mobile: ……

School/Nursery:.....…….. **Year Group**: ……

GP: …….. **Practice**: ……

Home Language: ..... **Interpreter Required?** Yes ☐ No ☐

Ethnicity (please tick one):

☐ British or Mixed British	☐ Irish	☐ Other White Background	☐ Caribbean
☐ White and Black Caribbean	☐ White and Black African	☐ White and Black Asian	☐ Chinese
☐ Other Mixed Background	☐ Indian or British Indian	☐ Pakistani or British Pakistani	☐ African
☐ Bangladeshi or British Bangladeshi	☐ Other Asian background	☐ Other Black Background	☐ Other

Medical History:

Medical diagnosis (if known):.....……

Any significant health problems?: ……

Concerns with hearing levels?: Yes ☐ No ☐

Education:

Does the child have a SEND? Yes ☐ No ☐ SEND Level: ……...

Current level of school / nursery support: ……..

☐ Autumn term ☐ Spring term ☐ Summer term

Current Support Services *Please list all professionals involved*:

Support Service	Contact Name & Telephone Number
☐ Paediatrician	
☐ Physiotherapist / Occupational Therapist	
☐ Educational Support	
☐ Health Visitor / School Nurse	
☐ Social Care	
☐ Family Support Worker	
☐ Other	

Continued overleaf

Area of Service referring into: ☐ Clinic Service ☐ School Service (*Please use the flowchart "Will the child be seen in clinic or school?")*

*If you have selected **School Service**, please confirm **ALL** of the following:*
☐ Understanding and / or using language is the main concern
☐ The child has a named 1:1 support in school who can carry out a regular therapy programme
☐ Name of the school communication champion: ……
Date of most recent communication champion training attended:……
☐ Details of graduated response to support communication (tier 1 strategies, tier 2 interventions)…….....

Highlight all areas of Concern *Please complete "Children's SLT Service – Communication Checklist". Electronic copies are available from the Speech and Language Therapy Service or on the Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust website.*

☐ Attention & Listening ☐ Interacting with Others ☐ Understanding Language
☐ Using Spoken Language ☐ Speech Sounds ☐ Stammering ☐Voice

Detailed information to support the referral based on your observations of the child:

……

……

……

Please give details of strategies / advice already in place:…..……
……

Previously known to Speech & Language Therapy?
☐ No ☐ Yes, please state reason for re-referral: .....

Any other information you feel would be useful:

……

Referrer Information:

Referral completed by: Name: ……..
Signature: ……..
Position: ……..
Base/ Address ……..
Telephone Number ……..

Date form completed: ……..

Parental Consent: *I agree to my child being referred to the Speech and Language Therapy Service and understand that I will need to attend an appointment at clinic or school.*

Parent / carer name: ……..
Parent / carer signature: ……..
Please note we are unable to process referrals without a parent / carer signature

When you have completed this form please send it to:
Children's Speech & Language Therapy Referrals, Child Development Centre, Doncaster Royal Infirmary, Armthorpe Road, Doncaster, DN2 5LT or dbth.paediatricsadmin@nhs.net
Any incomplete forms will be returned to the referrer.