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

Return via email to [wchc.childrenssaltteam@nhs.net](mailto:wchc.childrenssaltteam@nhs.net) or via SystmOne.

We cannot accept referral without consent from the person with Parental Responsibility

**Please fill in all sections of this referral form. Incomplete fields may result in your referral being rejected.**

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| **Section 1 - Patient Details** | | | | | | | |
| **Child’s Name:** | |  | | **Preferred Name (AKA):** | |  | |
| **Title:** | **Gender:** | **Date of Birth:** | **NHS No:** | **Parent/carer’s Contact:** | | | |
|  |  |  |  | **Name**: | **Tel:** | | |
| **Home Address (place of residence if different)** | | **Home Tel No:** | **Mobile:** | **School / Setting attending:** | | | |
| **Address**  **Postcode**: | |  |  | **Address:**  Postcode: | | | |
| **Parental/Carer or young person has consented to the referral.**  **Yes No** | | **G.P. Name**  **Practice Details:** | | **Interpreter required** | | | **Yes No** |
| **Main language is spoken:** | | |  |
| **Ethnicity:** | | |  |

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| **Section 2 - Additional Information:** |  |
| **Are there any safeguarding concerns?** | **Yes No** |
| **Are they a Child Looked After?** | **Yes No** |
| **Do they have a Social Worker?**  **Name/Contact details:** | **Yes No** |
| **Are they on a Child Protection Plan/ Child in Need Plan?**  **If yes, please expand** | **Yes No** |
| **Are there any lone working concerns?**  **If yes, please expand** | **Yes No** |
| **Is there an Early Help Plan?**  **URN:** | **Yes No** |
| **Does the child / young person have a Health Care Plan?** | **Yes No** |
| **Other agencies involved?**  **If yes, please give details:** | **Yes No** |

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| **Section 3 - *Other Professionals Involved*** | | |
| **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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| ***Section 4 - Reason for Referral*** | |
| **Please comment on the child’s ability in all the sections below if there are concerns.** | |
| **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?  If yes, please provide details below. | **Yes No** |
| **Fluency of speech (stammering)**  Is this an area of concern? | **Yes No** |
| **Any other information:** | |

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| ***Section 5 - Previous SLT/Audiology input*** | |
| **Has the child ever been referred to/seen by a Speech & Language before?** | **Yes No** |
| **If yes, please state when and the reason:** | |
| **What was the outcome?** | |
| **Has the child’s hearing been assessed (excluding birth check?)** | **Yes No** |
| **What were the results?** | |

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| ***Section 6- 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:*** | |

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| **Section 7 - Pre-referral Screening required – refer to referral guide and booklet** | | | |
| **WellComm screen carried out** | **Yes** | | **No**  **Please see the referral guide before submitting your referral** |
| **WellComm score sheets are attached to the referral** | **Yes** | | **No**  **Please see the 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** | **Date:** |

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| ***Section 8 - 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 messages and email reminders for appointments** | **Yes No** |
| **Name:**  **Signed:**  **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:** | |

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| ***Referrer Information***  **Name of referrer (please print):**  **Organisation:**  **Email address:**  **Address:**  **Postcode:**  **Designation:**  **Tel No.** |

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| ***Please return to the Speech and Language Therapy Department***  **Via post:** Children’s Speech & Language Therapy, Prenton Clinic, Prenton Village Road, Prenton, CH43 0TF  **Via email:** [wchc.childrenssaltteam@nhs.net](mailto:wchc.childrenssaltteam@nhs.net)  ***If you have any enquiries, please call our office on 0151 514 2334*** |