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

Return via email to 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***If you have any enquiries, please call our office on 0151 514 2334*** |