Date received:
Team:
Appointment Type:

Nottinghamshire County NHS
Teaching Primary Care Trust

Referral to the Children's Speech and Language Therapy Service

- **For students of secondary age, please complete this form, tick the box and send directly to Linden House, 261 Beechdale Road, Aspley, Nottingham, NG8 3EY** ❑
- Please use this form to refer any child (0 to end of school-age)
- Please complete all appropriate sections – referral can only be accepted if this form is completed fully
- Some sections may not be applicable – please indicate this by writing 'N/A'

SECTION A. Personal Information - Complete for all children

First Name _____ Surname/Family Name _____

Parent/Carer Name(s) _____ NHS No _____

Date Of Birth / / ❑ male ❑ female ❑ unknown

Address _____ Contact Telephone Number(s) _____

Postcode _____

Language(s) spoken at home _____

Interpreter/ signer needed? Child ❑ yes ❑ no Language(s) _____
Parent/ carer ❑ yes ❑ no Language(s) _____

Ethnicity

❑ White British	❑ Caribbean	❑ White & Black Caribbean	❑ Any other White background*
❑ Chinese	❑ Pakistani	❑ African	❑ Any other Black background*
❑ White Irish	❑ Bangladeshi	❑ White & Black African	❑ Any other Asian background*
❑ White & Asian	❑ Indian	❑ Any other ethnic group*	❑ Any other mixed background*
❑ Not given	❑ * if other, please state:		

Religion _____ Immigration Status (e.g. permanent, asylum seeker) _____

Other Carers: e.g. Grandparents, Childminder, Nanny

Name _____ Relationship to Child _____

Name _____ Relationship to Child _____

Previous Referral To Speech And Language Therapy ❑ yes ❑ no

If yes, give details (e.g. date, location, name of Speech and Language Therapist, reason for involvement/ non-attendance)

_____

SECTION B. Referrer Information

Name of Referrer

Role

Contact address

Contact Number

If taken over telephone:
Date:
Taken by:

Please remember your signature is required in Section I

SECTION C. Reason For Referral - Please state your concerns regarding the child's communication development

Please tick reason for referral:

❑ Assessment ❑ Treatment ❑ Advice ❑ Diagnosis ❑ Other

Please state any other relevant information including family history, family circumstances, social services involvement:

SECTION D: HEARING

Most recent hearing test: Date Result

Assessing agency

❑ Newborn Screen ❑ CHAC ❑ School Nurse ❑ Other (please state)

Is a hearing assessment required now?

❑ yes ❑ no

If unsure, please check below for important indicators:

❑ Parental concern

❑ Birth history indicators (such as premature birth, illness or use of antibiotics before, during or after birth)

❑ Family history of permanent hearing loss

❑ Medical history indicators (such as cranio-facial abnormalities e.g. cleft palate; serious illness such as measles or meningitis; head injury; persistent colds or ear infections; or syndrome)

❑ Other observed or reported concerns (such as frequent 'runny' nose; snoring; mouth breathing; unusual voice quality; frequent asking for repetition or mishearing information; does not always respond to what is said)

If you have ticked 2 or more, **please refer on for a hearing test**, and tell us which agency:

SECTION E. Please give a description of your concerns for this child in the following areas:

Attention & listening

Understanding spoken language (including following instructions)

Using spoken language (including putting words together, talking in sentences, telling stories)

Speech sound development (including sounds that are difficult to say and general intelligibility)

Social skills (interacting with others)

Stammering/fluency

Voice (including frequent harsh, husky or loss of voice quality)

Eating and Drinking

Describe how you have tried to help these difficulties

Have these strategies helped? What progress has been made?

SECTION F. Current Education Placement – Complete section (a) or (b) below

(a) Early Years Setting

e.g. playgroup, nursery (private/school) etc
If the child attends more than one setting, please give details for main placement. Please indicate the days and times attended.

Name of Placement

Key Contact

Telephone Number

Address

Attends on *(please circle)*

Monday	am	/	pm
Tuesday	am	/	pm
Wednesday	am	/	pm
Thursday	am	/	pm
Friday	am	/	pm

❑ Early Years School Action ❑ Early Years School Action Plus ❑ Statement

Support time available? ❑ yes ❑ no If yes, amount available

(b) School Setting

Name of Placement

Address

SENCO/ Key Contact

Class Teacher

Teaching Assistant

Telephone Number

Support time available? ❑ yes ❑ no If yes, amount and type available (in class, 1:1, group)

Level of Code of Practice *(please tick)*

❑ School Action ❑ School Action Plus ❑ Statement

Please include/attach additional relevant information

❑ Individual Education Plan/ National Curriculum Level	Other relevant information
❑ Assessment results	
❑ Minutes of recent review meetings	
❑ Other Agency reports	

SECTION G. Medical Conditions - Please provide details of any medical condition

Medical Condition/Disability

Date of Diagnosis & Diagnosing Agency

Further Details: e.g. medication, special requirements

SECTION H. Involved Professionals - Complete for all children

Health Visitor/School Nurse

Telephone Number

GP & Practice Address

Telephone Number

Community Paediatrician

Telephone Number

Education Support Services involved
e.g. Inclusive Education Service (City LEA) or Inclusion Support Service (County LEA), Educational Psychology Service, Behaviour Support Service, Early Years, Portage Early Education Team, etc

Name & Title

Work Base & Telephone Number

Name & Title

Work Base & Telephone Number

Social Services
e.g. Social Worker, Family Support Worker, etc

Name & Title

Work Base & Telephone Number

Has a Common Assessment Framework (CAF) been initiated? ❑ yes ❑ no ❑ don't know

Health
e.g. Physiotherapist, Occupational Therapist, Hospital Consultant, CAMHS, etc

Name & Title

Work Base & Telephone Number

SECTION I. Parental/Guardian Information – Please complete with parents at time of referral

Name of Parent/Guardian(s)

Parental/Guardian Comments – please offer any extra information you wish to give regarding your child's referral

Access to Speech and Language Therapy - please identify any reason why it may be difficult for parents/carers/child to access the service e.g. – language, literacy, physical or sensory needs

Parental/Guardian Consent

"I confirm that this referral has been explained to me by the Referrer, and that the information given on this referral form is correct. I agree to my child being referred to the Speech and Language Therapy Service." ☐ (please tick)

Signature of Parent/ Carer

Date

Relationship

Parental Responsibility ❑ yes ❑ no

Signature of Referrer

Date

SECTION J - Checklist

This referral will only be accepted by the Speech and Language Therapy Service if every section is completed. Please check the following sections to confirm their completion.

- ❑ Personal Information
- ❑ Medical Conditions
- ❑ Checklists
- ❑ Signature of Parent
- ❑ Involved Professionals
- ❑ Educational Placements
- ❑ Additional Information
- ❑ Signature of Referrer
- ❑ Referrer information
- ❑ Reason for referral
- ❑ Hearing information

Please send the completed form to your local Speech and Language Therapy Team.

If you are not sure which one this is please call Speech and Language Therapy at Linden House on 0115 883 4286, where our admin staff will be pleased to help you.