

**Nottingham Children’s Speech and Language Therapy (SLT) Service**

**Request for Support**

* The SLT service see children with significant communication difficulties and eating and drinking difficulties. These questions will help us to decide whether we are able to accept the request and decide on the most appropriate therapist to support the child.
* Please complete all appropriate sections and provide as much information as possible.
* Parents can refer in partnership with the child’s education/childcare setting.
* Referring agents other than Health Visiting or Schools teams, **such as GPs**, will need to liaise with relevant services to complete this request in order to provide the information required.
* **The request for support can only be accepted if this form is completed fully.** Where sections are not applicable, please indicate this by writing ‘N/A’.

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| **SECTION A. Personal Information – Complete for all children** | | | | | | | | |
|  |  | | |  | |  | |  |
| First Name | Click or tap here to enter text. | | | Surname/Family Name | | Click or tap here to enter text. | |  |
|  |  | | |  | |  | |  |
| Date of Birth | Click or tap to enter a date. | | | Gender | | Click or tap here to enter text. | |  |
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|  | | | | | *Please ask parent/carer to provide this:* | | |  |
| NHS No | Click or tap here to enter text. | |  |
|  |  | | |  | | | | |
| Address | Click or tap here to enter text. | | | Contact Telephone | | Click or tap here to enter text. | |  |
|  | Number(s) | |  |
|  |  | |  | |  |
| Postcode | Click or tap here to enter text. | | |  | | | |  |
|  | | | | | | | | |
| Parent/Carer  Name(s) | Click or tap here to enter text. | | | Parental Responsibility? | |  |  |  |
| Click or tap here to enter text. | | | Parental Responsibility? | |  |  |
|  | | | | | | | | |
| Name & contact details of person/body with Parental Responsibility, **if different from Parent/Carer**: | | | | Click or tap here to enter text. | | | |  |
|  | | | | | | | | |
| Email Address | Click or tap here to enter text. | | | | | | |  |
|  | | | | | | | |  |
| Ethnicity | Choose an item. | \* If other, please state: | | Click or tap here to enter text. | | | |  |
|  | | | | | | | | |
| Religion | Click or tap here to enter text. | | Immigration Status  (e.g. permanent, asylum seeker) | | | Click or tap here to enter text. | |  |
|  |  | |  | |  |
| If you consent to letters / appointments being sent by email, please tick here: | | | | | | | |
| We would like to contact you via SMS text messages about appointments. If you consent to SMS texts, please tick:  We may need to leave a voicemail message if we phone you. If you consent to voicemail, please tick: | | | | | | | |
| If you would like to opt out of receiving SMS text messages and/or voicemails from our service at any time, please call 0300 123 3387.  **Please note it is the responsibility of the person with parental responsibility to let us know of any changes in contact details. By consenting to this referral you agree for CCYPS services to use these methods of correspondence.** | | | | | | | |

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| **SLTs recognise bilingualism as an advantage. We use interpreters and our own bilingual staff to help us assess children’s skills in all languages they use and that other people use with them** | |
| Language(s) used to speak to the child | Click or tap here to enter text. |
| Language(s) used by the child | Click or tap here to enter text. |
| Any other language(s) used at home | Click or tap here to enter text. |
| Do parents require an interpreter? State Language. | Click or tap here to enter text. |

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| **SECTION B. Referrer Information** | |  |  | |
| Name of Referrer | | Role | |
|  | Click here to enter text. | Click here to enter text. |  |
|  | Contact address | Contact number |  |
|  | Click here to enter text. | Click here to enter text. |  |
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|  | **SECTION C. Medical Conditions – Please provide details of any medical condition**  Does the child have a medical condition / disability, and if so, do they have a diagnosis? | |  |
|  | Click here to enter text. | |  |
|  | | | |
|  | Date of Diagnosis & Diagnosing Agency | Click here to enter text. |  |
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| Further Details: e.g. medication, special requirements | |
| Click here to enter text. | |  |
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|  | **SECTION D. Family Information**  Has the child been seen by SLT previously?    If yes, please give details (where and when last seen, reasons) |  |
|  | Click here to enter text. |  |
| Are there concerns or indicators that the child may have an autistic spectrum disorder or social communication difficulties? If yes, please give details     |  | | --- | | Click or tap here to enter text. |   Has anyone else in the family had speech, language or communication difficulties? If yes, please give details. | | |
|  | Click here to enter text. |  |
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| **SECTION E. Hearing**  Do you think the child may have difficulty hearing? Yes/No If yes, please give details.  Click here to enter text. |
| Does the child wear hearing aids?      Has the child been referred for a hearing test?  If you have any concerns that the child may have a hearing difficulty, please refer to the Children’s Hearing  Assessment Centre |
| Does the child have hearing loss?  If yes please indicate:  Mild  (21-40db)  Moderate  (41-60 db)  Moderate- Severe  (61-70db)  Severe (71-90db)  Profound  ( >90)  Date detected:   |  | | --- | | Click here to enter text. | |

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| **SECTION F. Speech Language and Communication information**  When completing this section please consider the following (not all questions will apply to all children). For bilingual children, please add the language this relates to.   * How does your child get your attention? * How do they respond to other people? * What/who do they like to play with? * How do they respond when asked to do something? * How do they tell you what they need? * Do people understand what your child says? What sounds are they having difficulty with? Give examples of how your child is saying words. * Does your child have a stammer? What happens when they get stuck? * How would you describe your child’s voice? * If you are worried about your child’s eating or drinking please describe… | |
| **Parent/carer views** | **Setting/referrer views** |
| Are you worried? If so, what about? How long have you been concerned? (Please describe)  Click here to enter text. | Are you worried? If so, what about? (Please describe)  Click here to enter text. |
| How does it affect them on a daily basis?  Click here to enter text. | How does it affect them on a daily basis?  Click here to enter text. |
| How have you tried to help?  Click here to enter text. | How have you tried to help?  Click here to enter text. |
| What support do you want from SLT?  Click here to enter text. | What support do you want from SLT?  Click here to enter text. |
| Completed by:  Click here to enter text.  Relationship to child:  Click here to enter text. | Completed by:  Click here to enter text.  Relationship to child:  Click here to enter text. |

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| **SECTION G. Involved Professionals – Please provide details of any involved support services (from health and education). Have you asked anyone else for support?**  Click or tap here to enter text.  **Current Education/Childcare Placement** | | | | |
| e.g. playgroup, nursery (private/independent), child minder, mainstream school etc  If the child attends more than one setting, please give details for main placement. Indicate the days and times attended | | | | |
| Name of Placement | Click or tap here to enter text. | | | |
|  | | | | |
| Address | Click here to enter text. | Attends on | Monday |  |
|  |  | Tuesday |  |
| Wednesday |  |
| Thursday |  |
|  | Friday |  |
|  |  |  |  |  |
| Key Contact | Click here to enter text. | |  |  |
| **Attach additional relevant information:**  e.g. ECAT monitoring tool, ASQ document/summary, School-based assessments, Recent reports, National Curriculum/P-levels, EYFS, | | | | |
| Any other information you feel may be useful  Click here to enter text. | | | | |

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|  | **SECTION H. Parental/Guardian Consent – Please complete with parents at time of referral** | | | | | |  |
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|  | **I confirm that I have discussed my concerns with the parent/carer, and they:** | | | | | |  |
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|  | | * *Agree to their child being referred to the Speech and Language Therapy Service.* * *Have received information about what to expect following the referral from the referrer* * *Confirm that the information given on this referral form is correct* * *Understand that they will be contacted to opt-in and book an appointment.* * *Are aware that SLT information regarding their child, will be shared with other health professionals involved in their care, as part of the Safeguarding Young People Policy* | | | |  | |
|  | | | | | | | |
|  | Name of accountable professional | | Click here to enter text. | Date | Click here to enter a date. | |  |
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|  | **On completion of this form please make a copy for your own records and return as follows:**   * **Health professionals and Education:** [**childrensSLT@nottshc.nhs.uk**](mailto:childrensSLT@nottshc.nhs.uk)   This must be encrypted using the password, which has been provided by the CCYPS   * **Parents/Carers:**   **Speech and Language Therapy Referrals Admin**  **Children's Development Centre,**  **City Hospital Campus,**  **Hucknall Road,**  **Nottingham**  **NG5 1PB**  **Tel 0300 123 3387** |  |