



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):

- | | | | |
|---|---|---|------------------------------------|
| <input type="checkbox"/> British or Mixed British | <input type="checkbox"/> Irish | <input type="checkbox"/> Other White Background | <input type="checkbox"/> Caribbean |
| <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> White and Black African | <input type="checkbox"/> White and Black Asian | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Other Mixed Background | <input type="checkbox"/> Indian or British Indian | <input type="checkbox"/> Pakistani or British Pakistani | <input type="checkbox"/> African |
| <input type="checkbox"/> Bangladeshi or British Bangladeshi | <input type="checkbox"/> Other Asian background | <input type="checkbox"/> Other Black Background | <input type="checkbox"/> 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
<input type="checkbox"/> Paediatrician	
<input type="checkbox"/> Physiotherapist / Occupational Therapist	
<input type="checkbox"/> Educational Support	
<input type="checkbox"/> Health Visitor / School Nurse	
<input type="checkbox"/> Social Care	
<input type="checkbox"/> Family Support Worker	
<input type="checkbox"/> Other	

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.paediatricadmin@nhs.net

Any incomplete forms will be returned to the referrer.