positive about integrated healthcare

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Referral to the Nottingham Children's Speech and Language Therapy Service

- Complete all appropriate sections – Use this form, **together with checklist guide**, to refer children 0-18
- **Referring agents** other than Health Visiting or Schools teams, **such as GPs**, will need to liaise with relevant services to complete this referral: as much information as possible is required.
- Some sections may not be applicable – please indicate this by writing 'N/A'
- **The referral can only be accepted if this form and the checklist are completed fully.**

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

We may use SMS text messages for some appointments
Please tick this box if you do **NOT** wish to receive SMS text message reminders ☐

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)

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	
Language(s) used by the child	
Any other language(s) used at home	
Do parents require an interpreter? State Language.	

SLT input is more effective if someone is available to carry out regular practice. The referral may not be accepted if no-one is available to agree a plan and carry out SLT programmes of work. Please inform us who is able to support the SLT work? (select one or more)

☐ Family member/parent ☐ Setting support staff Other (Please specify)

SECTION B. Referrer Information

Name of Referrer

Role

Contact address

Contact number

If taken over the telephone:

Date:

Taken by:

SECTION C. Involved Professionals – Complete for all children

Please include dates of last/forthcoming appointments		
Agency	**Tick if involved**	**Name/Base**
Occupational Therapy		
Physiotherapy		
Paediatrician		
Audiology/ENT		
Social Services		
Looked After Child		
Team Around The Child		
Early Years Support		
Sure Start		
Education Inclusion Services		
Child and Family Service		
Other (Please specify)		

SECTION D. 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 E. Family Information/risk factors (at higher risk of SLCN)

Has anyone in the family had speech language or communication difficulties or Speech and Language Therapy Input?

☐ Yes ☐ No

If yes please give further information:

Has the child been seen by SLT previously

☐ Yes ☐ No

If yes please give details (where and when last seen. Reasons)

Are there concerns or indicators that the child may have an autistic spectrum disorder/social communication difficulties/global delay?

☐ Yes ☐ No

If yes please give further information:

Is there an EHAF/CAF/EHC Plan/Child Protection plan… If yes please give further details

SECTION F. Hearing

Does the child have a diagnosed hearing difficulty? If yes, please describe:

Do you think the child may have difficulty hearing?	(Please circle)	Yes	No
Has the child been referred for a hearing test?	(Please circle)	Yes	No

Consider referral for a hearing test if there is:

☐ Parental or school concern about the child's hearing

☐ Family history of permanent hearing loss

☐ History of frequent eat infections, glue ear or excessive wax

☐ Relevant medical history, such as pre-term birth, significant illness, a known syndrome

SECTION G. Speech Language and Communication information

Please give a description of your concerns for this child in the following areas, and state the language which difficulties are related to (for bilingual children) Put N/A is there are no concerns in that area:

Attention & listening

Understanding spoken language (including following instructions)

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

Speech sound development (ie list of sounds that are difficult to say; general intelligibility; specific tricky sounds)

Stammering/fluency (how long they have been stammering, are they aware; are there sound repetitions/prolongations/getting stuck)

Social skills (interacting with others) e.g. do they seek others to join in their play/is there a lack of interest in playing with others?

Eating and Drinking (concerns regarding the child's safety of swallow, or oro-motor difficulties impacting on respiratory health or nutrition/hydration)

Describe how you have tried to help these difficulties, and state whether this has helped/progress has been made?

SECTION H. 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			
Address		Attends on (Please circle)	Monday am / pm Tuesday am / pm Wednesday am / pm Thursday am / pm Friday am / pm
Key Contact			

Is support time available? Please give details (Time/support staff allocation)

Attach additional relevant information:

e.g. ECAT monitoring tool, ASQ document/summary, School-based assessments, Recent reports, National Curriculum/P-levels

Any other information you feel may be useful

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

Please note that SLT information regarding this child, will be shared with other health professionals involved in their care, as part of the Safeguarding Young People Policy

I agree to my child being referred to the Speech and Language Therapy Service.
Information about what to expect following the referral has been given to me by the Referrer.
I confirm that the information given on this referral form is correct.

For referrals other than Health Professionals, a parental signature will be required

Signature of Parent/Carer		Date	

Health Professionals Only
I confirm that consent has been given

Name and signature of accountable professional		Date	

On completion of this form please copy for your own records and send with the checklist to:

Speech and Language Therapy Referrals Admin
Stapleford Care Centre
Church Street
Stapleford
Notts
NG9 8DB
Tel 0115 8835187

To comply with Safe use of IT Policy, safeguarding patient identifiable information, please do not email this form.