**Children’s Speech and Language Therapy Referral Form**

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| **Child or young person’s details** |
| Name Click here to enter text. | DOB Click here to enter text. |
| NHS number Click here to enter text. | Gender: |
| Address Click here to enter text. | Name of Nursery/School/College provide here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  full time [ ]  part time |
| Parent 1 Name Click here to enter text.Parent 1 Phone number Click here to enter text.Parent 1 Email Click here to enter text.[ ]  address as above? If not provide here:Click here to enter text. | Parent 2 Name Click here to enter text.Parent 2 Phone number Click here to enter text.Parent 2 Email Click here to enter text.[ ]  address as above? If not provide here:Click here to enter text. |
| Interpreter required? Choose an item.Language spoken Click here to enter text. | Is the child or young person a Hackney looked after child? yes[ ]  no [ ] Are the family known to Social Care or Family Support (MAT)? Named Worker\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **Communication** | Tick any that apply | Please give details of your concerns:(referrals with no/limited information will not be accepted) |
| Difficulty understanding  |[ ]   |
| Difficulty using words and sentences  |[ ]   |
| Difficulty with social skills  |[ ]   |
| Play  |[ ]   |
| Clarity of speech  |[ ]   |
| Stammering  |[ ]   |
| Voice Quality e.g. hoarse or croaky  |[ ]   |
| Does not speak in certain environments? |[ ]   |
|  |  |
| **Eating, drinking and Swallowing**  | Tick any that apply | Please give details of your concerns:(referrals with no/limited information will not be accepted) |
| * Child has signs of difficulty when eating/drinking e.g. Coughing / gagging / watery eyes
 | [ ]  |  |
| * Child has repeated chest infections
 | [ ]  |  |
| * Faltering growth/failure to thrive
 |[ ]   |
| * Oro-motor difficulties impacting on chewing/manipulating food in the mouth
 |[ ]   |
| * Does the child/young person need food/drink textures to be altered in order to swallow safely?
 |[ ]   |
| * Any difficulties sucking e.g. breast/bottle feeding?
 |[ ]   |

Has the parent/carer consented to this referral? Yes [ ]  No[ ]

Please indicate which days the parent is able to attend:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Monday [ ]  | Tuesday [ ]  | Wednesday [ ]  | Thursday [ ]  | Friday [ ]  |

|  |  |
| --- | --- |
| Name of person completing form: | Telephone Number |
| Relationship to the child | Address |
| Date form completed:Click here to enter a date. |