**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. | |