**Paediatric Speech and Language Therapy Referral Form – Under 5 years**

**Please fill in all sections of this referral form. If these are not filled in the referral will be rejected from the service for insufficient information provided.**

Return via email to [wchc.childrenssaltteam@nhs.net](mailto:wchc.childrenssaltteam@nhs.net) or via SystmOne.

We cannot accept referral without consent from person with Parental Responsibility

|  |  |  |
| --- | --- | --- |
| **Section 1 - Parents.**  ***Personal Details***  **Child’s Name: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date of Birth: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHS No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Telephone Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **School/Setting attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Parent/Carer name/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Who has parental responsibility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Is the child currently a family member of the armed forces, reservist, or veteran? Yes  No ** | | |
| **Section 2**  ***Other Professionals Involved***  **GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Are there any safeguarding issues? Yes 🞏 No 🞏**  **If yes, what provision is currently in place for this, e.g. LAC, Child and Family, Child Protection, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Social worker’s name, base and contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   |  |  |  | | --- | --- | --- | | **Professional:** | **If involved, tick** | **Provide details (including name, contact no, etc.):** | | **Community Paediatrician** |  |  | | **Audiology** |  |  | | **Physiotherapist** |  |  | | **Portage** |  |  | | **Early Years Intervention Team** |  |  | | **Educational Psychologist** |  |  | | **Occupational therapist** |  |  | | **Any private providers** |  |  | | **Other** |  |  | | | |
| ***Reason for Referral***  **Please comment on the child’s ability in all the sections below if there are concerns.**   |  | | --- | | **Attention and Listening skills (in 1:1 and group settings):**  Is this an area of concern? Yes 🞏 No 🞏 | | **Comprehension (understanding of what people say):**  Is this an area of concern? Yes 🞏 No 🞏 | | **Expressive Language (sentences/grammar):**  Is this an area of concern? Yes 🞏 No 🞏 | | **Speech sounds (articulation/pronunciation):**  Is this an area of concern? Yes 🞏 No 🞏 | | **Social Communication Skills (interactions with others):**  Is this an area of concern?**Yes 🞏 No 🞏**  If yes, please provide details below. | | **Fluency of speech (stammering)**  Is this an area of concern?Yes 🞏 No 🞏 | | **Any other information:** | |  | | | |
| ***Previous SLT/Audiology input***  **Has the child ever been referred to/seen by a Speech & Language before: Yes 🞏 No 🞏**    **If yes, state when and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **What was the outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Has the child’s hearing been assessed (excluding birth check?) Yes 🞏 No 🞏**  **If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ What were the results?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Communication**  **Does the child use other methods of communication e.g., signing, gesture?**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Is English an additional language Yes 🞏 No 🞏**  **Would an interpreter be required? Yes 🞏 No 🞏**  **If yes, what is language and language level like in first language?**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| ***Educational Information***  **Does the child have an Education Health Care Plan? Yes 🞏 No 🞏**  **If yes, provide EHCP Co-ordinator’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Does the child have an Additional Support Plan? Yes 🞏 No 🞏**  **If yes, give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Does the child receive any other additional support in school? Yes 🞏 No 🞏**  **If yes, give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Pre-referral Screening required – refer to referral guide and booklet** | | |
| WellComm screen carried out | Yes 🞏 | No 🞏  Please see referral guide before submitting your referral |
| WellComm score sheets attached to referral. | Yes 🞏 | No 🞏  Please see referral guide before submitting your referral |
| WellComm intervention currently provided including frequency of input: | | |
| Phonology Screen Carried Out | Yes 🞏 | No 🞏 |
| Sounds and Listening Programme Completed? | Yes 🞏 No 🞏 | Date: |
| ***Parental/Carer Consent***  **I agree that this information about my child can be discussed / referred to a Speech & Language Therapist for advice** Yes 🞏 No 🞏  **I consent to the Speech and Language Therapy service sending text message and email reminders for appointments** Yes 🞏 No 🞏  **Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **If your child is school age and attends a Local Authority school, they will usually be seen in their usual school setting. If this is not appropriate, please let us know why:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| ***Referrer Information***  **Name of referrer (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Organisation­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| ***Please return Speech and Language Therapy Department***  **Via post:**  Children’s Speech & Language Therapy, Highfield Centre, Victoria Central Health Centre, Mill Lane, Wallasey, Wirral, CH44 5UF    **Via email:** [wchc.childrenssaltteam@nhs.net](mailto:wchc.childrenssaltteam@nhs.net)    ***If you have any enquiries, please call our office on 0151 514 2334*** | | |