SLT: 0002

REFERRAL FORM FOR CHILDREN

COMPLETE ALL SECTIONS

Forms with missing information cannot be accepted and will be returned causing delay

Mark relevant boxes with X

1 PERSONAL DETAILS

Name of child		D.O.B.	
Address		Home Tel no.	
		Home Post Code	
Next of kin/carer:		Email Address:	
Name of GP		GP Tel number	
Is the child:	A Child Looked After (CLA)? Yes / No	From a travelling family? Yes / No	
School/nursery contact details:		School's Tel number	

Is there a family history of speech/language difficulties?	Yes		No	

If yes, give details below:

Has the child attended any of the following universal/targeted Speech & Language groups? (please specify) N.B. We would expect some targeted-level input in the community/school before a referral to specialist service, if this is available
Pre-School Children: Flying Start/ Families First Early Language Support e.g. Chatty Children/ Elklan/ Talking Together (please specify):
School-aged Children: Targeted/small group support in school, e.g. attention and listening/language/social interaction/transition groups, Teaching Talking, groups from ComIT training (please specify):

Has this referral been discussed with and advised by one of the following:		
Speech and Language Therapist/Assistant:	Name:	
SLT/Advisory Teacher from Communication Intervention Team (ComIT)	Name:	
Special Schools Communication Forum	Name:	
ISCAN	Name:	
Flying Start	Name:	
Families First e.g. Integrated Family Learning, GAVO, Pathfinders	Name:	

2 WHAT HAS ALREADY BEEN TRIED?

What has happened already? How have you supported the child? Importantly - what was the outcome of this? How has the child responded?

3 EFFECT ON CHILD AT HOME

How are the difficulties of the child affecting their ability to communicate? Comment on social/emotional behaviour of the child, e.g. relationships with peers, self confidence, frustration or embarrassment.

How concerned are parents/carers?	Not concerned		A little concerned		Very concerned	

EFFECT ON CHILD AT PRE-SCHOOL/SCHOOL						
At pre school/school: (e.g. talk/interact/play with other children and adults)/access to curriculum including Foundation Phase. Comment on social/emotional behaviour of the child, e.g. relationships with peers, self confidence, frustration or embarrassment.						
How concerned are school staff?						
Not concerned:		A little concerned		Very concerned		

4	MEDICAL DIAGNOSIS AND MEDICATION (please attach any additional information/reports)							
	Hearing checked:	Yes		No		Date:		
	Vision checked:	Yes		No		Date:		

5	IF PREVIOUSLY DISCHARGED FROM SLT PLEASE STATE DISCHARGE REASON
	What is different now?
	If discharged for failing to contact the department or for non-attendance please specify what support is in place to enable the child/family to attend and engage with therapy.

6	REASON FOR REFERRAL (mark X to all that apply)	X
	Child has difficulties understanding spoken language (e.g. following instructions)	
	Child has difficulties using spoken language (e.g. words and sentences)	
	Child has difficulties with social interaction	
	Child's speech sounds are unclear/inaccurate (please include any examples in section 7 below)	
	Child stammers	
	Child has a hoarse or no voice (Voice referrals MUST have been seen by ENT prior to SLT)	
	Child has swallowing/feeding difficulties	
	Assessment for alternative augmentative communication (AAC) - communication aids, signing, use of pictures	
	Eating, drinking or swallowing difficulties - please describe the difficulties, and include details of recent respiratory health; physical development (e.g. does the child have head control and sitting balance); any digestive problems or problems of the mouth, teeth, tongue or oral hygiene and any history of non-oral (tube) feeding.	
	Other (Please specify:	

DESCRIPTION OF CURRENT SKILLS		
Indicate the level of attention and listening, (listening to instructions/attention to task). **Choose one**		
Level 1:	Can pay fleeting attention - highly distractable.	
7 Level 2:	Will only attend to own choice of activity.	
Level 3:	Single channelled attention - only concentrates on one activity at a time.	
Level 4:	Integrated attention - can concentrate on more than one activity.	

Indicate approximate level of play skills - taking turns, interacting with peers. **Choose one**.		
Level 1:	Exploratory play, e.g. putting toys in mouth.	
Level 2:	Simple pretend play e.g. brushing teddy's hair, feeding dolly	
Level 3:	Pretend play e.g. simple role play, tea party, make believe.	
Level 4:	Imaginative role play, involving peers.	

Comment on ability of child to follow instructions and on their level of understanding.

Describe vocalisations/way of making wishes known/spoken language of the child. Please include examples of speech sound errors (e.g. saying "tat" instead of "cat") here if this applies:

WHAT IS THE HOME LANGUAGE?						
English		Welsh		Other, please specify:		

8	Please give details about the child's skills in the home/first language (if this is not English)

Interpreter Required for Appointment with Family? Y/N	If yes, specify language	

WHO ELSE IS INVOLVED WITH THE CHILD (e.g. Educational Psychologist, Paediatrician, Social Worker)?

9	**SUPPORTING INFORMATION - Please send evidence of the child's speech and language skills in the context of other areas of development. Please see below for examples of what may be useful and tick what you are including. Your referral is unlikely to be accepted without evidence from the list below**	
	Schedule of Growing Skills (SOGS)	ComIT checklists (including repeated checklists following intervention)
	WellComm Checklists	National Curriculum Levels

Healthy Child Wales (HCW) Checklists	One-page profile with targets
Foundation Phase Profile (FPP)	Individual Development Plan (IDP)
Other Developmental Checklists	Educational Psychology Report
	Statement

10	**CONSENT : Parents/guardian must consent.**					
	Has the parent/guardian agreed to this referral?		Yes		No	

11	Is there any risk that SLT should be aware of? Please specify below:		Yes		No	
	Is wheelchair access required?		Yes		No	

	REFERRER DETAILS		
	Name of referrer (Print):		
	Designation of referrer (Print):		
12	Full Address: **(Complete address is required)**		
		Post Code	
	Tel No & Email Address:		
	Signature of referrer:		
	Date:		

RETURN ADDRESS:

SPEECH AND LANGUAGE THERAPY, BOOKING CENTRE, ABUHB HEADQUARTERS,

ST CADOC'S HOSPITAL, LODGE RD, CAERLEON, NP18 3XQ

PLEASE ENSURE THAT CORRECT POSTAGE IS APPLIED AS WE ARE UNABLE TO COLLECT ITEMS FROM THE POST OFFICE WITH INSUFFICIENT POSTAGE

IF EMAILING FORM:

ABB.SpeechAndLanguageAdminHub@wales.nhs.uk

IN THE SUBJECT LINE YOU MUST ENTER: 'REFERRAL FORM FOR CHILDREN'
FAILURE TO DO SO WILL RESULT IN DELAYS IN PROCESSING

FOR FURTHER INFO - ABUHB SPEECH & LANGUAGE WEB PAGES:

https://abuhb.nhs.wales/hospitals/a-z-of-services/speech-and-language-therapy/