|  |  |  |  |
| --- | --- | --- | --- |
| **Family Name:** |  | **Child’s first name(s):** |  |
| **NHS Number:** |  | **Date of Birth:** |  |
| **Trafford GP:**  |  |
| **Address:** |  |
| **Postcode:** |  | **Phone no:** |  |
| **Parent/Carer Email:** |  | **School/Nursery:** |  |
| **Language(s) child hears at home:** |  | **Interpreter needed?** | **For parent/carer?** | **Yes No** |
| **For child?** | **Yes No** |
| **Main language(s) used by child (if any):** |  | **Religion:** |  |
| **Hearing assessed?** | **Yes No** | **Results and date:** |  |
| **Ethnicity** | White – British |  | White - Irish |  | White - other |  | Not Stated |  |
| Mixed – White and Black Caribbean |  | Mixed – white and Black African |  | Mixed – White and Asian |  | Mixed – Any Other Mixed Background |  |
| Asian or Asian British - Indian |  | Asian or Asian British - Pakistani |  | Asian or Asian British - Bangladeshi |  | Asian or Asian British – Any Other Asian Background |  |
| Black or Black British - Caribbean |  | Black or Black British - African |  | Black or Black British – Any Other Black Background |  | Other Ethnic Groups - Chinese |  |
| Other Ethnic Groups – Any Other Ethnic Group |  |  |  |
| **Who else is involved with the child?** | Educational Psychologist |  | Teaching Assistant |  | ENT/Audiology |  |
| Healthy Young Minds |  | Paediatrician |  | TSISS |  |
| TEDS |  | SENAS |  | Social Services |  |
| Name of Social Worker (if applicable) |  |
| Other agencies/professionals involved: |  |
| **Is there any reason this family would find it difficult to attend an appointment?** **If yes, why?** | **YES NO** |
| **Has the child ever been known to Speech and Language Therapy in the past? E.g. for speech we often encourage re-referral after completion of home programme.** | **YES NO** |
| **Is the child seeing a private Speech and Language Therapist? If yes, please provide names and details.** | **YES NO** |
| **Parent/Carer Consent (we cannot accept a referral without this)** |
| I agree to this referral to Speech and Language Therapy. |  |
| I give permission for other professionals to be contacted about this referral e.g. school staff. | **YES NO** |
| I give permission for the S & L Therapist to assess/observe my child in school & liaise with school staff. | **YES NO** |
| I give permission for the S & L Therapy team to contact me via text and phone call  | **YES NO** |
| I give permission for the S & L Therapist to send me secure emails about my child. | **YES NO** |
| Parent/Carer Name:(print in BLOCK CAPITALS) |  | **Parent/Carer Signature:** |  | Date: |

|  |
| --- |
| **REFERRER DETAILS** |
| **Name:** | **Role:** |  |
| **Address:** | **Phone:** |  |
| **Email:** | **Signature:** |  | **Date:** |

**Referral tips**

* Complete **all** sections of this form.
* Send recent screening assessments (TASS/WellComm) **in full** to avoid rejection – remember to “screen to green”.
* TASS and WellComm – ideally less than 3 months old
* Please use the Pre-Referral Advice Line for any queries

(Wednesdays 9am -11am **07917 264 975**)

|  |
| --- |
| **Please use these boxes to help us form a picture of the child so we understand your concerns and why you are referring now. This will help us find the right pathway to assess the child.** |
| **Please describe in 1 sentence your main concern about the child’s speech, language and communication:** |
|  **Impact of SLCN:** describe the **impact** that needs in the following areas are having on day-to-day functioning**:** |
| **Social communication/interaction** e.g. finding it hard to make friends or take part in conversation with a variety of people |  |
| **Attention and listening** e.g. does this child need any extra help to focus on teaching in a small group or whole class? If yes, what helps the most? |  |
| **Play** e.g. child might find it hard to extend sequences of imaginative play or share play with others |  |
| **Understanding of language** e.g. do you need to use strategies to help understand: routine instructions; complex instructions. What helps? Visual timetable? Chunking language? |  |
| **Using language / expressive language** e.g. can they use language to get needs met? Learn and use new vocabulary? Use sentences like peers? If not, how do they communicate? |  |
| **Speech sounds and/or clarity** please note here if this is your main concern over and above other concerns – please include a TASS if speech sounds are your main concern – see link at top of this form. Does communication breakdown occur and impact on wellbeing? |  |
| **Stammering** e.g. child is finding it hard to communicate because they are repeating, prolonging or blocking sounds. If you have any speech or language concerns at all in addition to the stammer, please include a TASS and a WellComm.Are they aware or frustrated? Y/N |  |
| **Medical/developmental concerns** |  |
| **Is there a family history of speech, language and communication needs?** |  |
| **Please list the school-led pre-referral language intervention this child has already received and is receiving (e.g. colourful semantics, listening comp etc) Please attach your records and outcomes from the group(s)** |  |
| **What difference did this intervention make?** |  |
| **What are the child’s current communication goals?** |  |
| **For schools commissioning extra SaLT through SLA, please discuss with the SLA therapist pre-referral:** **I have included a TASS/WellComm and details of pre-referral intervention and would like the initial assessment carried out by the SST or clinic therapist □** **I have not included additional information and would like the SLA therapist to carry out the initial assessment □** |

**Referrals without this information will be rejected.**

* Referrers will be informed of the outcome of triage within 4 weeks so they can let parents/carers know.
* When we accept a referral, we aim to make initial contact within 18 weeks.

Please send completed forms and any additional supporting documents to:

**Speech and Language Therapy Service,**

**1st Floor, Sale Waterside, Sale, M33 7ZF**

*or email to:* **cslt@mft.nhs.uk**