North Tees and Hartlepool NHS
NHS Foundation Trust

Referral to Speech & Language Therapy for children and young people

Referrals can be made by anyone **providing there is parental consent.**
Young people assessed to be competent by the referrer are able to give consent for this referral.

Please complete all sections in black ink. Any forms which are illegible will be returned to the sender.

Name of parent(s)/carer(s): ____

Relationship to child/young person: ____________________ Who holds parental responsibility? _____________

Language(s) spoken at home: ________________________ Interpreter needed: yes/no

<table>
<tr><td colspan="2">Forename:</td><td>Surname:</td></tr>
<tr><td colspan="2">Gender: M/F</td><td>Date of birth:</td></tr>
<tr><td colspan="2" rowspan="3">Address:

Postcode:
Land line:
Mobile(s):</td><td>Protected address: yes/no</td></tr>
<tr><td>Name of school/nursery/pre-school:</td></tr>
<tr><td>Permission to contact via text: yes/no</td></tr>
<tr><td colspan="3">Safeguarding information (if applicable):</td></tr>
<tr><td colspan="3">What support/advice has the child/young person received to date? Please include any referrals to other services e.g. Educational Psychology, CAMHS.</td></tr>
<tr><td colspan="3">Medical information:

Does the child/young person have any specific diagnoses?</td></tr>
<tr><td>What difficulties is the child/young person having?</td><td colspan="2"></td></tr>
<tr><td>What impact is this having at home?</td><td colspan="2"></td></tr>
</table>

What impact is this having at nursery/pre-school/school/college?	
What are you hoping for from this referral?	

	None						Significant	
Level of parental concern	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Level of referrer's concern	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Level of child/young person's concern (if appropriate)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Has the child been referred to Speech and Language Therapy before?

Yes ◻ **No** ◻

Please provide any other information you think may be helpful to us.

Does the young person wish to be seen without their parent/carer? **Yes** ◻ **No** ◻
If yes, have they been assessed to be Fraser Competent? **Yes** ◻ **No** ◻

Referred by (please print):

Full name: ________________________ Job title: ________________________

Contact address: ____

Postcode: ________________________ Telephone number: ________________

Signature of referrer: ____________________ Date: ________________________

By signing this form you are confirming that you have obtained parental consent

Thank you for completing this form. You will be informed of the outcome of this referral.
Please return the completed form to the appropriate address below:

Speech and Language Therapy
Out of Hospital Care Services
University Hospital of Hartlepool
Holdforth Road
Hartlepool
TS24 9AH

Tel: 01429 522717
Fax: 01429 522722

Text Relay: 18001 01429 522712
Email: nth-tr.sltadmin@nhs.net