Referral to Speech & Language Therapy for Children and Young People

North Tees and Hartlepool NHS Foundation Trust

Section 1

This referral must be completed in conjunction with a parent/carer. Please see referral guidance for information on making a referral www.nth.nhs.uk/services/speech-language-therapy/children. If you are unsure about making a referral, please contact our service to discuss your concerns with a member of our team.

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

Speech and Language Therapy input is only effective if someone is available to carry out the recommendations. This referral will only be considered if someone is available to plan with the SLT and carry out programmes of work. Please provide the name of the person(s) who will support the SLT recommendations (e.g. family member, other carer, health professional, or member of staff in the educational setting).

Name _____ Relationship/role _____

Is this referral in relation to the child's:

Eating/drinking and swallowing ☐ **Communication** ☐ **Both** ☐

Section 2

Forename:	Surname:
Gender: M/F	Date of birth:
Address: Postcode: Land line: Mobile(s):	Protected address: yes/no
	Name of school/nursery/pre-school: Sessions attended (days/times): Year/Stage:
GP Practice: NHS No.:	Permission to contact via text: yes/no
Name of parent(s)/carer(s):	Relationship to child/young person:
Who holds parental responsibility?	Contact details of person with parental responsibility (if different):
Safeguarding information (if applicable): Is this a looked after child /young person? Yes ☐ No ☐ Is there a child protection plan? Yes ☐ No ☐ Category: Named Social Worker: Contact Details:	

Section 3

What languages are spoken at home? _____

What is the child's first language? _____

Is an interpreter required for the child / young person? Yes ☐ No ☐

Is an interpreter required for the parent / carer? Yes ☐ No ☐

Are the child/young person's language skills the same in all languages? Yes ☐ No ☐

Section 4

Medical information:

Does the child/young person have any specific diagnoses?

Are there any other developmental concerns about this child / young person?

What other professionals / services are involved?

Are there any hearing or vision concerns?

Section 5

Please indicate the difficulties the child / young person is having:

Area of concern	**No concern**	**Some concern**	**Significant concern**	**Describe the difficulties and what problems they are causing.**
Attention and Listening				
Understanding Spoken Language				
Using Spoken Language				
Use of speech sounds				
Social Interaction and Play				

Stammering				
Voice/vocal quality				
Eating, drinking and swallowing				

Section 6

Describe what you have already tried to help the child/ young person.

Has this been helpful? If so in what way?

What specific outcomes are you hoping for from this episode of care?

Section 7

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

Yes ☐ **No** ☐

If yes, what has changed since the child/young person was last known to Speech and Language Therapy?

Describe how the previous recommendations have been put in place?

Section 8

Learning/developmental progress

How is the child / young person making progress against expected levels?

Ahead of expected ☐ Within expected ☐ Below expected ☐ Significantly below ☐

Does the child / young person access any additional support? Yes ☐ No ☐

Have you sought any professional advice to support this child's learning? e.g. Educational Psychology, Advisory Teacher Yes ☐ No ☐

Please add details of professional below. Please gain consent and attach reports.

Does the child / young person have an EHCP? Yes ☐ No ☐

Does the child / young person have a support plan? Yes ☐ No ☐

Section 9

	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**

Please provide any other information you think may be helpful to us including the child / young person's views.

Section 10

Referred by (please print):

Full name: _____ Job title:_____

Contact address: _____

Postcode: _____ Telephone number: _____

Signature of referrer: _____ Date: _____

If you are an education professional, please tick to confirm that this referral has been discussed with your SENDCo ☐

Signature of Parent/Guardian: _____ Date: _____

Thank you for completing this form. We would recommend that you forward a copy of this referral to the child/young person's GP. You will be informed of the outcome of this referral.
Please return the completed form to the email or postal address below:

Children's Speech & Language Therapy
Children's Services Administration Hub
1st Floor, University Hospital of Hartlepool
Holdforth Road
Hartlepool
TS24 9AH

Tel: 01429 522717
Email: nth-tr.childrenservicesadminhub@nhs.net