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| T:\Communications\Logos\Shropshire Community Health\Office Use\Shropcom Logo - colour 2 line.png**Services for Children’s and Families**  |

**Children and Young People’s** **Speech and Language Therapy Service**

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| **Children and Young People School Age Referral Form** |

**Please ensure you complete all relevant areas of the form fully to avoid delay and assist us in processing this referral. Thank you.**

**We can provide some general information or advice to you without a re-referral through our advice line - on 01743 450800 (Option 4)**

**Has the child/young person been seen by our service within the last 12 months:**

If **Yes**: Please call our Admin Team on 01743 450800 (Option 4) to request an appointment for our Advice Line Team. You will be able to discuss your reasons for re-referral and possible next steps. Should you only need access to previously completed Training Package/s for a new staff member working with a child, please let our Admin Team know so this can be actioned.

If **No:** Please continue with this form

* If you have concerns about any of the following, please go straight to the **\*REFFERAL FORM**:
* Eating, drinking or swallowing difficulties
* Stammering / stuttering
* Selective Mutism
* Voice

 Please see our website for more information:[www.shropscommunityhealth.nhs.uk/childrenspeechlanguagetherapy](http://www.shropscommunityhealth.nhs.uk/childrenspeechlanguagetherapy)

* If you have concerns about **Speech**, please access the SLT website: [www.shropscommunityhealth.nhs.uk/chslt-speech-sounds](http://www.shropscommunityhealth.nhs.uk/chslt-speech-sounds) and look at *‘Use of speech sounds at a developmentally appropriate level’* and *‘What to look for’* in order to decide if a referral is needed.

As children develop their speech and language skills, it is important to think about their understanding of language, their talking (using words and sentences) and their speech (speaking clearly).

If you are still concerned about speech, please complete this \***REFFERAL FORM** along with the completed ‘Mini Speech Screen’.

* If you are a **Parent/Carer** – please call 01743 450800 (Option 4) to make an Advice Line appointment – do not complete this form.

**Referral Criteria for Settings:**

* You must complete a screening tool for one of the following interventions and follow the referral criteria for your chosen screening (please see referral flow chart in **Appendix A**)

**Talk Boost, WellComm, NELI, Stoke Speaks Out:**

* The difficulties identified must be out of line with the child / young person’s overall level of development or be having a significant impact beyond what would be expected by their level of learning and cognition.
* Unless there have been significant changes for a child or young person, we do not accept referrals from Education colleagues for children during Year 6 in primary or beyond Year 8 in secondary schools as we expect all concerns to have been identified sooner. This does not affect referrals for Stammering / Stuttering / Voice / Selective Mutism.

**Have Parents / Carers and the child been informed about this referral and have they signed the box in Section C to indicate this? Yes** [ ]  **No** [ ]

Please provide information relating to your re-referral below

**\*REFERRAL FORM:**

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| **A. Child’s Details**  |
| Child’s Full Name: |  |
| Date of Birth: |  | NHS No: |  |
| Resident address andPost Code: |  |
| **Additional details**  |
| Parent/Carer Name(s): |  |
| Mobile Tel no:  |  |
| Home Tel no: |  |
| Email address: |  |
| Other Parent/Carer Name and address (if different from child): |  |
| Mobile Tel no:  |  |
| Home Tel no: |  |
| Email address: |  |
| Name of Parent/Carer(s) with parental responsibility: |  |
| The child / young person * Is a Looked After Child
* Has a child protection plan?
* Has a disabilities plan?
* Identified as SEND Support?
* Has an EHCP?
 | Yes [ ]  No [ ]  Don’t Know [ ] Yes [ ]  No [ ]  Don’t Know [ ] Yes [ ]  No [ ]  Don’t Know [ ] Yes [ ]  No [ ]  Don’t Know [ ] Yes [ ]  No [ ]  Don’t Know [ ]  |
| Home Languages  |  | Interpreter needed Parent: Yes [ ]  No [ ]  Interpreter needed Child: Yes [ ]  No [ ]   |
| GP address and contact details |  |
| Other professionals and contact details |  |

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| **B. Referral Details** |
| Does the child have any diagnoses?  | Yes [ ]  No [ ]  Don’t Know [ ]   |
| Diagnoses given |  |
| Information about the Intervention:(please see **Appendix A** for information) | Name of Intervention (e.g. NELI, TalkBoost, etc.). | Score on the initialScreeni.e. Red / Amber | Number oftimes intervention completed | Score onfollow-up screen i.e. Red / Amber |
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| Briefly describe why are you referring this child and what you want the outcome of our involvement to be? For the child/young person:Some children have **speech** difficulties which are not expected during development.These include (please indicate ‘yes/no’ as appropriate): * Over 3 years old and parent/carer cannot understand most of the time. YES / NO
* Over 3 years old and less than 5 different consonant sounds produced on the Mini Speech Screen. YES / NO
* Over 3 years old and often does not repeat the words when asked (check words with a dash (-) on the Mini Speech screen). YES / NO
* Over 4 years and new people cannot understand most of the time. YES / NO
* Over 4 years old and does not repeat p, t, c/k, f, s accurately as single sounds. YES / NO
* Over 4 years and often did not say the words on their own (check words marked with an asterisk (\*) on the Mini Speech Screen). YES / NO
* Any age and always misses sounds off at the beginning of words, e.g. 'food', - 'ood', 'duck' - 'uck'. YES / NO
* Any age and always changes sounds to c/k or g, e.g. 'two' - 'coo', 'sea' - 'key', 'ball' - 'gall'. YES / NO

For your Staff/ the child’s family: e.g. Access to training. Please describe any training in SLCN the lead people supporting the child have.What advice have you given to the Parents / Carers? |
| **SCHOOL / SENCO REFERRALS ONLY**: Please include any recent relevant reports, including from LSATS / EPs, school based assessments academic achievements profiles. Our usual practice is to ask you to follow at least one specific piece of advice related to SLCN from these reports for two terms before considering referring to SLT for further detailed assessment. The talking point website has a progress checking function <http://www.talkingpoint.org.uk/Parent/Directory/Progress-Checker.aspx>  |
| Please indicate your comparison between the child’s speech, language and communication and other areas of learning or development |
| **C.**  **Informed** |
| 1. Under the General Data Protection Regulation (GDPR) we are required to inform our patients and service users of how their information will be used.  We have done this through a Privacy Notice which is available on the Shropshire Community Health Trust Website: <https://www.shropscommunityhealth.nhs.uk/>

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/carer full name) agree that my child, identified above, can be referred to the Children’s Speech and Language Therapy Team. I have been made aware of the Shropshire Community Trust Privacy notice. 1. I (parent/carer) agree to receiving correspondence / documents by email.

Preferred email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Parents/Carers signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. Children are usually offered a clinic appointment for initial assessment. Would you

foresee any difficulties with regard to attendance (e.g. transport / childcare difficulties) **YES / NO** |
| 1. Please indicate if you would like to be informed of the date of the child’s initial appointment **YES / NO**
 |
| **D. Referrer Contact Details** |
| Referrer Name |  |
| Job Title |  | Dept / Organisation |  |
| Referrer Address |  |
| Referrer Tel No. |  | Mobile No. |  |
| Referrer email |  |
| Date of Referral |  |
| **E. School Details (if different from Section D)** |
| Name of School  |  |
| Full Address (Inc. postal code) |  |
| Tel No. |  |
| Contact email address |  |
| SENCO & contact person e.g. TA supporting the child |  |

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| **Thank you for completing this form****Please return via Secure Email to:** shropcom.childtherapyreferrals@nhs.net**Speech and Language Therapy Advice Line****We are offering a telephone advice service for Parents, and Education staff in Shropshire and Telford and Wrekin to answer**1. **General queries without a referral for example about:**
	* **Whether a referral or re-referral to the service is needed**
	* **Sourcing equipment or activity ideas related to speech and language interventions**
2. **Specific queries about an individual child or young person’s needs or development, which will require a referral**

 **Please contact us via Telephone: 01743 450800 (Option 4) A black background with a black square  Description automatically generated with medium confidence** |

Collecting information about your ethnic group

In order to help the NHS understand the needs of patients and service users from different groups and to comply with the Race Relations (Amendment) Act 2000, we need to collect information about your child’s ethnic group. This information will be treated confidentially and will not be shared with any other organisation.

Everyone belongs to an ethnic group. By collecting this information the NHS will be able to identify those groups more at risk of specific diseases and their care needs and so provide better, and more appropriate services for you and your family.

The attached list of 16 ethnic groups are the standard categories. Using these codes will help us to compare information about the groups using our services and assist us in providing for our local population.

It is important that where possible your child is able to describe their own ethnic group. If this is not possible, then parents/carers should enter this information on behalf of their child.

Thank you for taking the time to provide this useful information.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ NHS no: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Ethnic group** |
| What is your ethnic group? Choose ONE section from A to E, then tick the appropriate box to indicate your ethnic group |
| **A: White****¨** British**¨** Irish**¨** Any other White background (please write in)  |
| **B: Mixed** **¨** White and Black Caribbean**¨** White and Black African**¨** White and Asian**¨** Any other Mixed background (please write in)  |
| **C: Asian or Asian British** **¨** Indian**¨** Pakistani**¨** Bangladeshi**¨** Any other Asian background (please write in)   |
| **D: Black or Black British** **¨** Caribbean**¨** African**¨** Any other Black background (please write in)  |
| **E: Chinese or other ethnic group** **¨** Chinese**¨** Any other (please write in)  |

**Referral Criteria for Settings** **Appendix A**

