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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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| **Re-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.**

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

**Yes** [ ]  **No** [ ]

**If No then please complete a referral form which can be found on our website at** [**https://www.shropscommunityhealth.nhs.uk**](https://www.shropscommunityhealth.nhs.uk) **🡺 For patients & carers 🡺A-Z of services 🡺Speech and Language Therapy**

**Re-referral**

The demand for speech and language therapy is very high. We ask you to very carefully consider your decision to re-refer a child or young person to the service. The locally commissioned speech and language therapy service does not generally provide continuous long-term intervention. Please consider the following:

* Referring to the previous intervention plans and discharge report from the Speech and Language Therapist for information and advice.
* How/why you need our help specifically (see re-referral criteria below\*)

Please **highlight your main reason(s) for seeking further SLT input**

[ ]  The child’s profile of eating, drinking / swallowing or communication has changed meaning they have a new functional difficulty

[ ]  The child or young person has reached a point of transition

[ ]  The current intervention plan has been completed and you need further advice to understand any barriers to success or extend the child’s skills

[ ]  The current intervention plan has been completed and you need a reassessment

[ ]  The team supporting this child has changed and they need to access training

[ ]  The team supporting this child would value a training re-fresher

**\*Re-referral Criteria**

* The child’s functional difficulties are significantly impacting on his or her performance with communication.
* A child / young person must present with needs in one or more of the following areas. This website has some helpful information about speech, language and communication development

<https://www.thecommunicationtrust.org.uk/resources/resources/resources-for-practitioners/universally-speaking/> <https://www.thecommunicationtrust.org.uk/media/363850/tct_univspeak_5-11.pdf>):

* + Understanding of language/following instructions
	+ Using words and putting words into sentences and narratives
	+ Use of speech sounds at a developmentally appropriate level
	+ Fluency at a developmentally appropriate level
	+ Eating, drinking or swallowing difficulties at a developmentally appropriate level
* 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
* You can make a re-referral to children’s SLT at any time within 12 months of the child or young person being discharged up to the age of 18.

**Have parents / carers and the child or young person been informed about this referral and has a parent signed the box in Section C to agree to this referral? Yes** [ ]  **No** [ ]

Please provide information relating to your re-referral below

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| **A. Child’s Details**  |
| Child’s Name: |  |
| Date of Birth: |  | NHS No: |  |
| **Additional details** **(where different from original referral). Please include information about both parents if they do not live at the same address.** |
| Address (include post code): |  |
| Parent’s/Carer’s Name(s): |  |
| Parent/Carer Address if different from child |  |
| Mobile No: Home No: |  |
| Is the child/young person is a Looked After Child?  | Yes [ ]  No [ ]  Don’t Know [ ]  |
| **B. Referral Details** |
| Does your child have a newdiagnosis since we last saw them? | Yes [ ]  No [ ]  Don’t Know [ ]   |
| Diagnoses given |  |
| New or Functional Eating, drinking / swallowing or Communication needs | List Interventions already being carried out (e.g. direct vocabulary teaching) | Duration (e.g. over past 6 months) | Frequency e.g. 3 x weekly 20 mins small group) | Outcome (e.g. no progress, new vocabulary not retained/great progress) |
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| Briefly describe why are you re-referring this child and what you want the outcome of our involvement to be?For the childFor your staff/ the child’s family e.g. Access to training ( see note 1 for options) |
| **SCHOOL/SENCO REFERRALS ONLY**: Please include any recent relevant reports, Provision maps, referrals to other agencies including academic achievements |
| Please indicate your comparison between progress with the child’s speech, language and communication and other areas of learning or development |
| **C.**  **Informed** |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parents/carers full name) agree that my child, identified above, can be re-referred to the Children’s Speech and Language Therapy Team. I have been made aware of the Shropshire Community Trust Privacy notice. **Parents/Carers signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( for children under 16)****Young person’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( if 16 or over)****Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **D. Referrer Contact Details** |
| Referrer Name |  |
| Job Title |  | Dept/Organisation |  |
| Referrer Address |  | email contact |  |
| Tel No |  | Mobile |  |
| Date of Referral |  |
| **E. School Details (if different from original referral or different from Section D)** |
| School/Nursery / Early Years Setting |  |
| Address (Inc. postal code) |  |
| Tel No |  |
| Contact email address  |  |
| SENCO |  |
| **Thank you for completing this form.** **Please return via:****Post to:**Children’s Speech and Language Therapy AdministrationShropshire Community Health NHS TrustCoral House11 Longbow CloseHarlescott LaneShrewsburySY1 3GZ**Secure Email to:** shropcom.childtherapyreferrals@nhs.net**Re-referrals may be directed to the Advice Line for support (see below).** |
| **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 queries about:*** **Whether a referral or re-referral to the service is needed**
* **Sourcing equipment or activity ideas related to speech and language therapy**

**Please contact us via:****Telephone: 01743 450800** |

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*Notes to support completion of the form*

1. *Training options for support staff in settings and for parents/carers*
* Using Visuals, to support understanding and related behaviours
* Attention and Listening, Tracking and Supporting
* Derbyshire Language Scheme Information Carrying Words, Tracking and supporting Understanding
* Levels of Questioning – Adults asking and Children answering questions (Blank Rose and Berlin), Tracking and Supporting
* Vocabulary, Tracking and Supporting Understanding and Spoken Language