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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 child  For 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 Administration  Shropshire Community Health NHS Trust  Coral House  11 Longbow Close  Harlescott Lane  Shrewsbury  SY1 3GZ  **Secure Email to:**  [shropcom.childtherapyreferrals@nhs.net](mailto: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