**Children’s speech and language therapy**

**referral form guidance - communication**

**Please complete this form if you have concerns about a child’s communication. This includes the understanding and use of language, speech sounds, and social interaction.**

If you have concerns about a child’s fluency, voice or eating and drinking please use an alternative form available on the website here: <https://www.bdct.nhs.uk/how-to-refer-a-child/>

**Before completing this form, please refer to the referral criteria for communication available here** <https://www.bdct.nhs.uk/how-to-refer-a-child/> **to help you decide if a referral to speech and language therapy is appropriate.**

**You must use a screening tool to help you to decide if the child meets the referral criteria. These are available on our webpages here:** <https://www.bdct.nhs.uk/how-to-refer-a-child/>. Completed screening tools should be included with your referral.

**Please ensure all relevant parts of the referral form are completed, if not, your referral may be rejected.**

**Prioritisation**

Our service prioritises referrals based on:

**Need** – including level of functional impact, risk factors for persistent difficulties, level of parental concern.

**Risk** – including significant social, emotional, and mental health concerns, safe-guarding concerns

**Timing** – including transition, education and health care plans.

**Team around the child** – including level of support required at home and within setting

**Episodes of care**

We currently follow an episode of care model. An Episode of Care will be different depending on the child’s needs at that time. We will assess the child. We will then work with the family and staff involved to help them to feel confident in supporting the child’s communication needs. The child will then be discharged with information about when and how to re-access the service. The time between each episode (a minimum of 8 weeks) should be used to follow the advice given and to practise the activities given by the speech and language therapy team.

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**Information governance**

This form **may be** forwarded to speech & language by email to:

[Fax-HPK.Admin-Hub@bdct.nhs.uk](mailto:Fax-HPK.Admin-Hub@bdct.nhs.uk)

but must be appropriately secured as it contains confidential /sensitive information.

Alternatively, fax 01274 215660

**Please note that we require parent/ carer consent for the referral & sharing of relevant information to have been discussed and obtained prior to completion of this form. we are unable to see children without this.**

1. **Consent for referral to speech and language therapy**

|  |  |  |
| --- | --- | --- |
| **Please tick to confirm if you have discussed and gained consent for the following with parent/carer.** | **Yes** | **No** |
| **Referral to the Speech and Language Therapy Service**  **(including, if appropriate, to assessment, treatment, and school visits):** |  |  |
| **Sharing of records with other health & education professionals:** |  |  |
| **Receiving SMS text appointments:** |  |  |

Please confirm that you, as the person with parental responsibility, consent to the referral to speech and language therapy for your child. Please also confirm you consent to the sharing of information with health and education professionals. You can find out more about how we collect, store, and share information at the following:

<https://www.bdct.nhs.uk/service-users-carers/your-health-records-data-protection/>

<https://www.bdct.nhs.uk/wp-content/uploads/2018/05/B-SLT-pdf.pdf>

**Parent / Carer signature:** ……………………………….……………………

**Date:**  ………………………………

1. **Parent / family details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent name/s:** |  | | |
| **Parent’s main language:** |  | | |
| **Does the parent require an interpreter?** | Yes / No | **Preferred gender of interpreter:** | Male / Female / Either |
| **Family history of speech & language difficulties (please state diagnosis):** |  | | |

1. **Child’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Forename:** |  | **Surname**  **(family name):** |  |
| **Known as:** |  | **Gender:** |  |
| **Date of birth:** |  | **NHS number (if known):** |  |
| **Address:** |  | | |
| **Postcode:** |  | **Telephone No:** |  |
| **GP practice /**  **GP name:** |  | **Mobile No:** |  |
| **Religion:** |  | **Ethnic origin** |  |
| **Child’s main language:** |  | **Child’s other language/s:** |  |
| **Nursery / School:** |  | **Health visitor:** |  |
| **Medical diagnosis:** |  | | |
| **Other professionals involved e.g., paediatrician, audiology:** |  | | |

1. **Safeguarding and risk**

|  |
| --- |
| **Please state any relevant information relating to safeguarding and/or risk:** |
|  |

1. **Timing**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Is the child about to transition from one environment to another?**  **(e.g. nursery to primary e.g. primary to secondary)** |  |  |
| **Is the child currently under-going assessment for an education and health care plan?** |  |  |
| **Is there a need for input due to a significant change to the child’s EHCP through the annual review process?** |  |  |

1. **Reason/s for referral**

|  |  |
| --- | --- |
| **Please give specific information about how the child meets the referral criteria- see referral criteriadocument on pg 1. Please include completed screening tools- see link on pg 1.**  **Give as much detail as possible. If detail is not provided the referral may be rejected.**  **If the child/young person’s first language is not English, please describe the child’s skills in their first language (you can complete the screening tool with family/carers).** | |
| **Understanding of language** |  |
| **Expressive language** |  |
| **Speech sounds** |  |
| **Social skills and interaction** |  |

1. **Universal strategies and targeted intervention**

It is important that the child/young person has had support at a universal and targeted level before referral for specialist support, The impact of this support should be monitored and described in this referral. If this information is not provided your referral may be rejected.

|  |
| --- |
| **Please state what universal strategies / quality first teaching techniques you have already used to support the child/young person:**  (Please ensure that you describe the SPECIFIC strategies you have recommended and tried based on the child’s specific needs. Use the screening tool to guide you. You can find information on specific strategies on our website). |
|  |
| **Did the strategies help? How did they help?** |
|  |
| **Please state what targeted interventions you have already used to support the child/young person:**  **(If you have planned an intervention or referred to a service for targeted support, please ensure the child has accessed this support before referring to our service).** |
|  |
| **Did the intervention help? How did it help?** |
|  |

1. **Impact of speech, language, and communication needs**

|  |
| --- |
| **What impact do these difficulties have on the child or young person? Think about the child’s participation, engagement in everyday activities and the emotional well-being of the child. Please give details below:** |
|  |
| **What impact do these difficulties have on the family? Think about the family’s ability to understand their child’s needs. Think about the family’s confidence in supporting their child’s needs. Think about the emotional well-being of family members. Please give details below:** |
|  |

1. **Outcomes**

|  |
| --- |
| **Describe what you want to achieve because of this referral. What aspect of the child/young person’s speech, language or communication difficulties do you hope will improve in the next 6-12 months?** |
|  |
| **Who in the child’s life can support the child’s speech, language, and communication needs? Please give details below** |
|  |

1. **Referrer’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer name:** |  | **Referrer address:** |  |
| **Referrer role:** |  | **Referrer phone number:** |  |

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Is this referral for a commissioned session within your setting?** |  |  |

**Referrer’s signature:** ……………………………….……………………

**Date:** ………………………………

**Please return completed form to:**

[Fax-HPK.Admin-Hub@bdct.nhs.uk](mailto:Fax-HPK.Admin-Hub@bdct.nhs.uk)

Fax: 01274 215660