**Paediatric speech and language therapy**

**referral form guidance – multiple concerns**

**Please complete this form if you have concerns about more than one of the following:**

* **A child’s communication.** This includes the understanding and use of language, speech sounds, and social interaction.
* **A child’s stammering.**
* **A child’s eating and drinking.**
* **A child’s voice.**

If you have concerns **about only one** of the above, please use an alternative form available on the website here: <https://www.bdct.nhs.uk/how-to-refer-a-child/>

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

If one of the concerns is communication, 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.

**For all referrals complete sections 1-6** and then the appropriate sections for each concern referred for:

* Communication- sections **7-10** [**Click for Communication**](#Communication)
* Stammering- section **11** [**Click for Stammering**](#Stammering)
* Eating and Drinking- sections **12-13** [**Click for Dysphagia**](#Dysphagia)
* Voice- section **14** [**Click for Voice**](#Voice)

**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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**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.**

**Information governance**

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

Fax-HPK.Admin-Hub@bdct.nhs.uk

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

Alternatively, fax 01274 215660

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:** |   | **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. **Referrer’s details**

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

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

**Date:** ………………………………

**Once all relevant sections have been completed, please return completed form to:**

Fax-HPK.Admin-Hub@bdct.nhs.uk

Fax: 01274 215660

**Communication concerns**

1. **Reason/s for referral- communication**

|  |
| --- |
| **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.** |
| **Understanding of language** |  |
| **Expressive language** |  |
| **Speech sounds** |  |
| **Social skills and interaction** |  |

1. **Universal strategies and targeted intervention- communication**

It is important that you have considered what universal strategies and targeted interventions you are able to offer to support the child / young person before referring to our service.

If this information is not provided your referral may be rejected.

Please see information on universal advice here <https://www.bdct.nhs.uk/services/childrens-speech-and-language-therapy/>. **Please look under the appropriate age-range.**

|  |
| --- |
| **Please state what universal strategies / quality first teaching techniques you have already used to support the child/young person:****What impact did these have?** |
|  |
| **Please state what targeted interventions you have already used to support the child/young person:****What impact did these have?** |
|  |

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- communication**

|  |
| --- |
| **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** |
|  |

**Stammering Concerns**

1. **Reason/s for referral- Stammering**

|  |
| --- |
| **Describe your concerns regarding the child / young person stammering****Give as much detail as possible. If detail is not provided the referral may be rejected.** |
| **Please give details / examples of the child’s difficulties & when they started***e.g., repeating parts of words e.g. ‘c..c..c..can’, ‘stretching parts of words e.g. ‘ssssock’, child tries to talk but no sound comes out at all, extra body movements/ tension e.g. stamping feet, child/parental anxiety, avoidance of speaking e.g. situations or words.* |  |
| **What impact do these difficulties have on the child or young person?** *e.g., on self-esteem, avoidance, friendships/ family; anxiety/ setting; inclusion, attainment*  |  |
| **Describe what you want to achieve because of this referral** *e.g., increased participation from the child, to improve the well-being of the child, to raise staff’s awareness of the child’s difficulties, support for parents, advice and strategies to support the child’s development etc*  |  |

**Eating and Drinking Concerns**

1. **Reason/s for referral- Eating and Drinking**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **Has the child received previous input from Speech & Language Therapy?** **If yes, provide the date on the child’s last report / mealtime guidelines below** |  |  |
|  |  |
| **Has the child’s eating and / or drinking changed since their last report?** **If yes, provide details of how below** |  |  |
|  |  |
| **Do the previous guidelines remain appropriate?** **If no, provide details of why not below** |  |  |
|  |  |
| **If this is a Health Visitor referral, has the Health Visitor observed this child eating?** **(If not, this referral may be rejected)****Please detail the advice given by the Health Visitor below** |  |  |
|  |  |
| **Please explain clearly what you are expecting the Speech & Language Therapy Service to provide** |
|  |

1. **Current eating and drinking regime**

|  |
| --- |
| **Type of Feeding** |
| **Gastrostomy Fed** | **Oral Feeding** |
| **Yes** |  | **No** |  | **Yes** |  | **No** |  |
| **Drink** |
| **Normal** | **Thickened** |
| **Yes** |  | **No** |  | **Yes** |  | **No** |  |
| **Food** |
| **Normal** | **Mashed** | **Pureed** |
| **Yes** |  | **No** |  | **Yes** |  | **No** |  | **Yes** |  | **No** |  |
| **Amount usually eaten** |
|  |

**Voice Concerns**

1. **Referral Information- Voice**

To access voice therapy the child must have had a relevant ENT assessment in the past 6 months.

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **Has the child been assessed by ENT in the last 6 months?** **If yes, please provide details below.**  |  |  |
|  |  |  |
| **Has the child received previous input from Speech & Language Therapy for a voice issue?** **If yes, provide details below** |  |  |
|  |  |
| **Does the previous advice remain appropriate?** **If no, provide details of why not below** |  |  |
|  |  |
| **Please describe the child’s voice problem**  |
|  |