***(For office use only)***

*Date referral received:*

A close-up of a logo

Description automatically generatedChildren’s Speech and Language Therapy Service

**Referral Form**

|  |  |
| --- | --- |
| **Information Governance**  **Please note that we require parents/carer consent for the referral and sharing of relevant information to have been discussed and obtained prior to completion of this form. We are unable to see the child without this.** | This formcan be sent to LCH CSLT Service by email to: [lcht.slt.leedsreferrals@nhs.net](mailto:lcht.slt.leedsreferrals@nhs.net) but must be appropriately secured as it contains confidential /sensitive information.  Alternatively post to **Central CSLT Admin Team, Leeds Community Healthcare, Building 3, White Rose Park, Millshaw Park Lane, Leeds, LS11 0DL** |
| Prior to completing this form, please read the following points;   1. **Please consult the** **Leeds Speech and Language Therapy Service Referral Guidelines Children and Young People** to ensure that your referral is appropriate. The guidelines are in the referrals section of our website at: [www.leedscommunityhealthcare.nhs.uk/cslt](http://www.leedscommunityhealthcare.nhs.uk/cslt) 2. **Health professionals (including GPs) who use SysmOne** must access and send an electronic referral via SystmOne. 3. All **other GPs and professionals** can complete the form below and send to CSLT using the contact details above. 4. Please **provide as much detail about the impact of the child’s difficulties** that you can. If there is insufficient information the referral is likely to be rejected. | |

|  |  |  |
| --- | --- | --- |
| 1. **Parent / Carer consent has been gained for:**  **DATE** discussed with parent/carer. | DD/MM/YY | |
|  | YES | NO |
| \*Referral to the Speech and Language Therapy Service |  |  |
| \*Sharing of records with other childcare, education & health professionals: |  |  |
| \*Receive communication via SMS text or email e.g. appointments: |  |  |
| Have a Student Speech and Language Therapist participate in the assessment and therapy sessions: |  |  |

1. \***Child’s Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Name: |  | Surname: |  | Known As: |  |
| Date of Birth: |  | | Gender: | Male / Female | |
| Address: |  | | | | |
| Postcode: |  | | NHS Number (if known): |  | |
| GP Name: |  | | GP Practice: |  | |
| Medical Diagnosis: |  | | | | |

1. **\*Parent/ Family Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Parent/Carer Name/s: |  | | Relationship to child: |  | |
| Telephone No: |  | | Mobile: |  | |
| Email Address: |  | | Parent/Carer agreed to being contacted by email | | YES  NO |
| Child’s Main Language |  | | Child’s other language/s: |  | |
| Parent’s Main Language: |  | | Dialect: |  | |
| Does the **parent** require an interpreter: | YES  NO | Does the **child** require an interpreter: | YES  NO | Preferred gender of interpreter: | Male / Female / Either |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **Safeguarding:** | | | | YES | NO |
| \*I am aware of safeguarding concerns regarding this child: | | | |  |  |
| Is a Social Worker involved with the family? | | | |  |  |
| Please state the named contact: |  | Contact No or E-mail: |  | | |

1. **School/Nursery Details:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \*Setting Name |  | | Key contact in setting (include name and role): |  |
| Setting Address: |  | | | |
| Postcode: |  | | Telephone No: |  |
| **If you are referring from an education or childcare setting please complete this additional information:** | | | | |
| Does your setting commission a Speech & Language Therapist? NHS or Independent | | YES  NO  If yes, provide SLT Name and contact details: | | |
| SLT Targets supported in the setting by in-house SLTs. | | Date of last report:  Details of support: | | |
| Is this a referral to your Traded SLTs caseload? | | YES  NO | | |
| EYFS / NATIONAL CURRICULUM / PIVATS LEVELS |  | | | |
| Have attached a copy of the summary page of a screen assessment?  Referrals will not be accepted unless a screening assessment has been carried out (except where a recent independent SLT report has been provided). | | | | YES  NO |
| EHCP | YES  NO  in progress | |  |  |

1. **Nature of the Concern**: In the next section p*rovide* details of the concern regarding the child’s speech and language development in the following areas.

* **Interaction:** interaction with adults and peers, initiating and maintaining conversations.
* **Understanding Language:** ability to follow routines, instructions, questions, understanding of words.
* **Expressive Language**: words used, vocabulary, sentence length, grammar, use of gesture.
* **Speech:** clarity of speech, pronunciation of sounds, articulation, substitution of sounds, missing sounds
* **Stammer/ Stutter**: Under 6 years, 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. For children over 6 years who stammer please use this [alternative referral form](https://www.leedscommunityhealthcare.nhs.uk/seecmsfile/?id=4600)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Mark level of concern | | \*Where a concern is identified please give examples of the child’s difficulties |
| **Interaction** | No Concern |  |  |
| Possible Concern |  |  |
| Definite Concern |  |  |
| **Understanding Language** | No Concern |  |  |
| Possible Concern |  |  |
| Definite Concern: |  |  |
| **Expressive Language** | No Concern |  |  |
| Possible Concern |  |  |
| Definite Concern: |  |  |
| **Speech** | No Concerns |  |  |
| Possible Concern |  |  |
| Definite Concern: |  |  |
| **Stammering** | No Concern |  |  |
| Possible Concern |  |  |
| Definite Concern: |  |  |

1. **Reason/s for referral**

|  |  |
| --- | --- |
| \*Parents/Carers concerns |  |
| \*What is the impact of the child’s difficulty on the child; self-esteem, avoidance, friendships/ family; anxiety/ setting; inclusion, attainment (please describe): |  |
| \*What strategies/ interventions have you already tried?  What was the impact/outcome of this support? |  |
| \* What aspect of the child/young person’s speech, language or communication difficulties do you hope will improve in the next 6-12 months? For example   * 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. |  |

1. **Other professionals:** Please state name and contact information if known of other Health/ Education Professionals involved

|  |  |  |  |
| --- | --- | --- | --- |
| **PROFESSIONAL** | **CONTACT DETAILS:**  **(Name & Number/ email)** | **PROFESSIONAL** | **CONTACT DETAILS:**  **(Name & Number/ email)** |
| Educational Psychologist |  | Paediatrician |  |
| SENIT |  | Physiotherapy |  |
| STARs |  | Occupational Therapy |  |
| Audiology |  | CYPMH/CAMHS |  |
| Do you have concerns regarding the child’s hearing? | YES  NO | Independent SLT |  |
| If yes, has a referral to audiology been made? | YES  NO | School Nurse/ Health Visitor |  |

**\*PLEASE NOTE THAT INSUFFICIENT REFERRAL INFORMATION MAY DELAY THE REFERRAL PROCESS. THIS FORM WILL BE RETURNED TO THE REFERRER IF IT IS NOT FULLY COMPLETED.**

1. **\*Details of the referrer:**

|  |  |
| --- | --- |
| NAME: |  |
| DESIGNATION: |  |
| ADDRESS: |  |
| E-MAIL: |  |
| TELEPHONE NUMBER: |  |
| DATE: |  |

**NB if returning this form by email the contents of this email (and any attachment) are confidential, may be legally privileged and is intended solely for the use of the individual or entity to whom it is addressed. It may not be disclosed to or used by anyone other than this addressee, nor may it be copied in any way. If you have received this email in error, you should not disclose its contents, copy or relay it on in any way. Please inform us by reply of the error and delete it from your system. You may also contact Leeds Community Healthcare NHS Trust on +44 (0)113 220 8500 quoting the name of the sender and the addressee and then delete it from your system. Please note that neither Leeds Community Healthcare NHS Trust nor the sender accepts any responsibility for viruses, and it is your responsibility to scan the email and attachments (if any). I understand that any communication via email either from or to me from the service will be recorded within my record and held in line with the Trusts record keeping policy.**