# Completing a Speech and Language Therapy Referral – Guidance Document

**Please use this document in conjunction with the SLT Referral Guidelines (version 4, October 2021).**

This guidance accompanies the launch of an updated referral form that is available in a pdf format and as an electronic form, which can be completed and printed out. The address to send the completed forms to is outlined on the form itself.

The referral form update comes after gathering informal feedback through our everyday work, as well as some internal quality improvement projects looking at the information we receive on referrals and the subsequent clinical decision-making after a consultation with parents. The update will:

- Allow us to make more informed decisions, earlier in a child's care
- Provide us with more information about the key people in the child's life that are going to support change for that child
- Providing us with more information about the supportive strategies that are already in place.

**Important things to consider before completing a referral:**

- Have you checked the referral guidelines to support your decision-making?
- If the child falls into the 'amber' / 'monitor' category, what have you put in place as your first steps along the graduated response (e.g. Talk Boost, specific strategies, additional phonological awareness work)? What impact did this have?
- SLT speech screener – this **MUST** be completed if the primary concern is speech clarity.

**When completing a referral, key things to remember are:**

- Parental consent must be gained – this can be verbal and does not require a signature. Please note the three different consent sections that should be carefully explained to parents and consent indicated for all three areas (SLCN practitioner, information sharing, email contact). *If consent for the SLCN practitioner is not indicated as 'yes', then the referral will not be accepted. Children can still be accepted on to the caseload if parents indicate 'no' to the other areas of consent.*

- Complete ALL sections of the referral form, even if that is to highlight that there are no concerns in a certain area.
- Outline what has already been put in to place to support this child and family and how successful this has been.
- Provide supporting documentation - supporting the referral documentation with additional information about what you have noticed, what you have tried and any additional documentation you have, helps us to build the most detailed picture of a child much more quickly. This is really important to supplement the information we gain from parents during our triage and initial assessment. We want a rounded picture of a child and we all know that children often present differently in the home and in the nursery / school. Including information about what you have tried already and how a child has responded, helps us to provide the most appropriate recommendations, rather than things that have already been tried and not been fruitful.

**Supporting information / documentation examples:**

- Inclusion Toolkit S&L assessment (Northumberland)
- Communication Toolbox assessment (North Tyneside)
- Passport and / or SEND checker (Northumberland)
- Tiny Talkers report (Northumberland)
- Trackers – Talk Boost, Launchpad for Literacy, ECAT, BLAST
- Children's SEND profiles