

Paediatric Speech and Language Therapy – Referral Form

Please complete all sections of the form – both sides of A4

Child's name: Click or tap here to enter text.	NHS number: Click or tap here to enter text.
DOB: Click or tap here to enter text.	Parent / carer name(s): Click or tap here to enter text.
Address: Click or tap here to enter text.	Email: Click or tap here to enter text.
Protected address yes <input type="checkbox"/> no <input type="checkbox"/>	Phone number: Click or tap here to enter text.

Referrer name: Click or tap here to enter text.	School / Nursery: Click or tap here to enter text.
Job title: Click or tap here to enter text.	Key contact: Click or tap here to enter text.
Full Address: Click or tap here to enter text.	Phone: Click or tap here to enter text.
Phone: Click or tap here to enter text.	Email: Click or tap here to enter text.
Email: Click or tap here to enter text.	
EHA: yes <input type="checkbox"/> no <input type="checkbox"/>	Attendance pattern: full time / part time (specify days) Click or tap here to enter text.
Lead: Click or tap here to enter text.	
Phone: Click or tap here to enter text.	
Email: Click or tap here to enter text.	
GP: Click or tap here to enter text.	Health Visitor (if not referrer): Click or tap here to enter text.
Other professional involvement (check boxes as appropriate): Children's Services <input type="checkbox"/> CYPs (NL) / CAMHS (NT) <input type="checkbox"/> Educational Psychology <input type="checkbox"/> Primary Mental Health <input type="checkbox"/> Paediatrician <input type="checkbox"/> Audiology <input type="checkbox"/> ENT <input type="checkbox"/> Portage <input type="checkbox"/> Other (please specify) Click or tap here to enter text.	

Reason for referral/Areas of concern (please comment in all boxes, even if to highlight that there are no concerns):	
Play: Click or tap here to enter text.	Listening and attention: Click or tap here to enter text.
Understanding language: Click or tap here to enter text.	Using language (how do they communicate?): Click or tap here to enter text.
Social interaction: Click or tap here to enter text.	Speech clarity: Click or tap here to enter text.
Eating, drinking and swallowing: Click or tap here to enter text.	Other (include additional medical needs, stammering, voice, reluctant talking): Click or tap here to enter text.
Please outline support / strategies / interventions currently in place, or tried to date: Click or tap here to enter text.	
Additional supporting information (please highlight and include with the referral where appropriate):	
Communication Toolbox (NT) <input type="checkbox"/>	Inclusion Toolkit (NL) <input type="checkbox"/>
Other trackers (e.g. Launchpad for Literacy; Talk Boost) <input type="checkbox"/>	Passport / SEND Checker (NL) <input type="checkbox"/>
SLT speech screener <input type="checkbox"/>	Tiny Talkers (referral / completed) <input type="checkbox"/>

Parental Consent (please provide parents with the information in the following boxes and indicate whether they give consent for each individual area):	
SLCN practitioner – your child may be seen by Speech and Language Therapists (SLT), Assistant Speech and Language Therapists (ASLT), or Student Speech and Language Therapists (under SLT supervision); do you consent to this?	Choose an item.
Information sharing – to ensure the appropriate support is provided, it is often necessary to seek information from and share information with other professionals	Choose an item.

involved in your child's care (e.g. Education staff, Health Visitors, Paediatricians etc.); do you consent to this?	
<p>Email contact - Not all email communication is secure. There is a small chance emails for you, about your child, could be seen by people other than you or the SLT. With this information in mind, do you consent to receiving identifiable information (e.g. your child's name, date of birth, address) via email from the SLT team?</p> <p>If at any time you no longer wish to be contacted via email, please contact your Speech and Language Therapist</p>	Choose an item.
<p>Date: Click or tap to enter a date.</p>	

ETHNICITY	Choose an item.
MAIN SPOKEN LANGUAGE	Choose an item. Other (*Please specify): Click or tap here to enter text.

<p>PLEASE RETURN FORM TO: SLT Admin Team, Paediatric Speech and Language Therapy, Shiremoor Resource Centre, Earsdon Road, Shiremoor, NE27 0HJ</p>
