Paediatric Speech and Language Therapy – Referral Form
Please complete all sections of the form – both sides of A4

Northumbria Healthcare NHS Foundation Trust

Child's name:	NHS number:
DOB: Address: Protected address (highlight) – yes / no	**Parent / carer name(s):** Email: Phone number:

Referrer name: Job title: Full Address: Email: Phone:	**School / Nursery:** Key contact: Phone: Email:
EHA: yes / no Lead: Phone: Email:	Attendance pattern: full time / part time (specify days)
GP:	**Health Visitor (if not referrer):**
Other professional involvement (highlight or delete as appropriate): Children's Services / CYPS (NL) / CAMHS (NT) / Educational Psychology / Primary Mental Health / Paediatrician / Audiology / ENT / Portage / Other (please specify) –	

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

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?	Yes / No
Information sharing – to ensure the appropriate support is provided, it is often necessary to seek information from and share information with other professionals involved in your child's care (e.g. Education staff, Health Visitors, Paediatricians etc.); do you consent to this?	Yes / No
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? If at any time you no longer wish to be contacted via email, please contact your Speech and Language Therapist.	Yes / No
Date:	

ETHNICITY				**MAIN SPOKEN LANGUAGE**			
British or mixed British		Bangladeshi or British Bangladeshi		English		Punjabi	
Irish		Other Asian background		Albanian		Russian	
Other white background		Caribbean		Arabic		Somali	
White & Black Caribbean		African		Bengali		Spanish	
White & Black African		Other Black background		Cantonese		Turkish	
White & Asian		Chinese		Croatian		Urdu	
Other mixed background		Other ethnic category		Farsi		Vietnamese	
Indian or British Indian		Ethnic category not stated		French		Other (please specify)	
Pakistani or British Pakistani				Germa		Italian	
				Greek		Japanese	
				Guajarati		Polish	
				Hindi		Portuguese	

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