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| **WARRINGTON PAEDIATRIC SPEECH AND LANGUAGE THERAPY REFERRAL FORM** | | | | | | | | | | | |
| For advice on who you should consider referring (select appropriate age range for child), please visit: [***http://www.bridgewater.nhs.uk/warrington/paediatricspeechandlanguagetherapy/referrals***](http://www.bridgewater.nhs.uk/warrington/paediatricspeechandlanguagetherapy/referrals) | | | | | | | | | | | |
| **Child’s Details** | | | | | | | | | | | |
| Child’s first name/s: | | | | | | | | Child’s family name: | | | |
| Address: | | | | | | | | | | Postcode: | |
| Gender: | DOB: | | | | | | | | | NHS No: | |
| Tel: | | | Mobile: | | | | | | | Email: | |
| Preferred method of contact: phone / email (please circle/ delete) | | | | | | | | | | | |
| GP Name: | | | GP Address: | | | | | | | Ethnic Category: | |
| What is the child’s main language? | | | | | | | | | | | |
| Please list all languages the child hears or speaks at home or on a regular basis: | | | | | | | | | | | |
| * English * Arabic * Bengali * Chinese-Cantonese * Chinese-Mandarin * Czech * Farsi * Hindi * Hungarian * Kurdish * Latvian * Pashto * Polish * Punjabi * Romanian * Slovak * Tamil * Turkish * Urdu | | **Hear** | | **Speak** | | | **Other**: (Please specify)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| ***For children with English as an additional language refer if limited progress is made after 6 months and the child has regularly attended an English speaking environment.*** | | | | | | | | | | | |
| Interpreter needed for parents? | | | | | | | | | | Yes / No | |
| Will parents require reports/advice to be translated from English? | | | | | | | | | | Yes / No | |
| **Any existing diagnosis / medical conditions?** | | | | | | | | | |  | |
| **Any known allergies?** | | | | | | | | | |  | |
| **Any medication?** | | | | | | | | | |  | |
| **Details of all persons with Parental Responsibility** | | | | | | | | | | | |
| Name | | | | | | | | Name | | | |
| Relationship to child | | | | | | | | Relationship to child | | | |
| Address: (if different from above)  Postcode: Tel: Mobile: | | | | | | | | Address: (if different from above)  Postcode: Tel: Mobile: | | | |
| Does the parent/s have any disabilities or support needs? Yes / No (please circle/ delete) Comments: | | | | | | | | | | | |
| Child in Care:  Known to Social services:  Previously known: | | | | | Yes / No  Yes / No  Yes / No | | | | | | |
| Social Worker: Base: Tel: Email: | | | | | | | | | | | |
| **Childcare / Pre-school / Educational Setting** | | | | | | | | | | | |
| Name of setting: | | | | | | | | | | | |
| Address: | | | | | | | | | | | Postcode: |
| Name of SENDCo: | | | | | | | | | Tel: | | |
| Full time / part time  Please state days/times: | | | | | | Does this child have an EHCP? Yes / No | | | | | |

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| **Key people/agencies involved (past or present)** Please attach any relevant information from these people (e.g. Reports, strategies or interventions), ensuring parental/carer’s consent has been given. | | | |
| Agency: | | Name, Base and Tel: | |
| Audiology/ENT | |  | |
| Educational Psychologist | |  | |
| Consultant Paediatrician | |  | |
| CAMHS | |  | |
| LA Support Worker | |  | |
| Health Visitor/School Nurse | |  | |
| Occupational Therapist | |  | |
| Physiotherapist | |  | |
| Other | |  | |
| **Reason for referral (Forms lacking adequate detailed information will delay appropriate next steps for this child. We suggest that professionals complete this form in partnership with parents/carers).** | | | |
| **Please tick which areas the child / young person is experiencing difficulties with:** | | | **Please comment how these difficulties are affecting the child / young person:** |
|  | **Early communication skills (e.g. turn taking, play, eye contact, pointing etc…)** | |  |
|  | **Child / Young person’s understanding of spoken language** | |  |
|  | **Ability to express themself (e.g. speech, gesture or signs, symbols, communication aids etc…)** | |  |
|  | **Speech sound difficulties / clarity of speech** | |  |
|  | **Social interaction skills** | |  |
|  | **Stammering (difficulty with fluency)** | |  |
|  | **Eating and/or drinking skills** | | Please complete the ‘eating and drinking concerns’ form found at the back of the referral form. |
|  | **Other Information or developmental information  (e.g. Diagnoses, birth history, delayed milestones’, hearing, educational concerns, difficulties with attention and listening etc…).** | |  |

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| **How does this child / young person’s ability to communicate differ from their abilities in other areas? (e.g. play / drawing / model making etc…).** |
| **What strategies / techniques have parents / carers used to try to overcome these difficulties?**  **How effective were they? e.g. Chatterbox/Wellcomm activities** |
| **What strategies / techniques have nursery / pre-school / school tried to support this child / young person? How effective were they? Chatterbox/Wellcomm activities/ visual supports/ universal class room (Quality First Teaching) strategies.** |
| **What do nursery / pre-school / school hope to gain from this referral?**  **Does school have staff members in place to support/deliver a SLT programme? Yes / No** |
| **What do parents / carers hope to gain from this referral?** |
| **What does the child / young person hope to gain from this referral? Are they aware of differences between them and their peers? *Please ensure you have asked the child/young person if they are able to express an opinion.*** |
| **Are there any difficulties or issues that parents / carers would prefer to discuss without the child / young person being present?** |
| **Please circle/delete as appropriate parents / carers preferred Clinic** |
| Grappenhall Sandy Lane (Orford) Wolves |
| **Are there any issues associated with offering home visits to this family (e.g. parent / carer’s working hours, safety of staff etc…)** |
| **Any additional issues you need SLT to be aware of (e.g. copies of appointment letters need to be sent to school)** |

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| **Referrer Details** | |
| Referrer’s Name: | Role: |
| Referrer’s contact address: | |
| Referrer’s Tel: | Referrer’s Email: |
| Referrer’s Signature: | Date: |

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| **Referrer Checklist** |
| All parts of the referral form have been filled out in full  Parents are in agreement with referral to Speech and Language Therapy (essential)  **Written** parental consent form has been completed and is attached   * **Non Health Professional referrers only (see next page)** |
| **If you would like any help completing this form or if you have any questions please contact the Speech and Language Therapy Team on 01925 946686**  **Please return completed referral forms to:**  [**bchft.paediatricsaltadmin@nhs.net**](mailto:bchft.paediatricsaltadmin@nhs.net)  Warrington Paediatric Speech and Language Therapy Service, Health Services at Wolves, Martin Dawes Stand, Winwick Road, Warrington WA2 7NE |

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| **Consent for Referral to Speech and Language Therapy** (Please note written consent must be obtained from the parent/carer with parental responsibility for the child).  FOR NON HEALTH PROFESSIONALS REFERRALS ONLY i.e. education/ nurseries/ Children’s Centres |
| **Child’s Name: D.O.B:**  **Have you discussed this referral with the child/young person? Yes / No (please circle)**  **If No, please give a specific reason.**  Confidentiality of my child’s information and consent to sharing of information  has been discussed with me by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name). **Yes / No (please circle)**  I give consent for my child ……………………………………… to be referred to  the Speech and Language Therapy Service. **Yes / No (please circle)**  I give my consent for Warrington Speech and Language Therapy Department to share all speech and language therapy information, reports and programmes with:  Relevant Health Care staff **Yes / No (please circle)**  Relevant Education and Children Centre staff  **Yes / No (please circle)**  Social care staff **Yes / No (please circle)**  I give my consent to share information relating to my child’s appointment times and attendance at appointments with the above people **Yes / No (please circle)**  I give consent to Speech and Language Therapists to ask the above people for further information about my child where required, for my child’s Speech and  Language treatment. **Yes / No (please circle)**  I have had the issue of consent explained to me, I understand that I am under no obligation to give consent to any of the above. I have circled where I have given consent.  I understand that I can withdraw my consent at any time.  **Parent / Carer Name (Print).…………………………………………………………………………………….**  **Signature………………………………………………………..…….… Date: .………/……..……/……….**  **Relationship to child (please state and / or tick below): ……….…………………………………………**  **Parent  Parental responsibility   Legal Guardian** |

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| **EATING & DRINKING CONCERNS**  **Please only complete this form if the child has a swallowing problem of a mechanical nature (not behavioural).**  **Referral for behavioural feeding problems (e.g. if child is able to eat a range of food textures successfully but prefers to eat a limited range of tastes such as crisps or chicken nuggets) are not appropriate.** |

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| **During feeding** | **Yes** | **No** |
| Child coughs/chokes during feed:   * Solids and liquids * Liquids only   If yes, then please give examples of what solids/liquids child coughs/chokes on: |  |  |
| Child frequently clears throat during/after feed |  |  |
| Child becomes red in face during feed |  |  |
| Eyes water during feed |  |  |

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| **Respiratory difficulties** | **Yes** | **No** |
| Suffers from recurrent chest infections |  |  |
| Suffers from recurrent bouts of pneumonia |  |  |
| Has wheezy/gurgly sounding breathing around mealtimes |  |  |
| Does child suffer from asthma? |  |  |

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| **Reflux** | **Yes** | **No** |
| Is the child on any anti-reflux medication?  If yes, please name: |  |  |

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| **Weight** | **Yes** | **No** |
| Has the child lost weight? |  |  |
| Is the child underweight? |  |  |
| Are you concerned over rate of weight gain? |  |  |

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| **Position/Seating** |
| Please state normal seat/position in which child is fed e.g. on parent’s knee, high chair, specialist seating or standing frame, etc. |

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| **Meals/snacks** |
| Please give some examples of meals/snacks your child eats. |

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| **Additional information** | **Yes** | **No** |
| Does the child see a Dietician? |  |  |
| Does the child tire easily (particularly during feeds)? |  |  |
| Does child have difficulty chewing food? |  |  |
| Does the child have a nasto-gastric (NG) tube? |  |  |
| Does the child have a gastrostomy (PEG) fitted? |  |  |
| Is there anything else you would like us to know about child’s feeding? |  |  |
| What is your **main concern** about child’s eating/drinking skills? |  |  |

**If the child is vomiting frequently and therefore refusing food they should be referred either to their GP or to a Paediatrician for medical** **investigation rather than to Speech and Language Therapy Feeding Clinic.**