|  |
| --- |
| **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 / NoYes / NoYes / 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  |

|  |
| --- |
| **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…).** |  |

|  |
| --- |
| **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)** |

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

|  |
| --- |
| **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**Warrington Paediatric Speech and Language Therapy Service,Health Services at Wolves,Martin Dawes Stand,Winwick Road,WarringtonWA2 7NE |

|  |
| --- |
| **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 toshare 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 timesand attendance at appointments with the above people **Yes / No (please circle)**I give consent to Speech and Language Therapists to ask the above people forfurther 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** |

|  |
| --- |
| **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.** |

|  |  |  |
| --- | --- | --- |
| **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 |  |  |

|  |  |  |
| --- | --- | --- |
| **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? |  |  |

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

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

|  |
| --- |
| **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. |

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

|  |  |  |
| --- | --- | --- |
| **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.**