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| **SPEECH & LANGUAGE THERAPY SERVICE** **RE-REFERRAL FORM**Print Code:XXX Version: V2 |
| **This** **referral form is only for children who have been discharged from the Speech and Language Therapy within the last 12 months and who require re-referral for further support with communication.** Dysphagia referrals: please complete the *Paediatric Speech and Language Therapy Community Referral: Eating and Drinking* form  |
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| **1. CHILD’S DETAILS** |
| Child’s Name: | [ ]  Male [ ]  Female |
| NHS No: | DOB: |
| Full Names of Parent / Guardian / Carer\*: *\*Please specify and indicate person/s with parental responsibility* |
| Address: |
| Postcode: |  |
| Home Tel: | Mobile: |
| Email address:  |
| Languages spoken: | Interpreter Required: [ ]  Yes [ ]  No |
| Is there an Early Help / CIN / or Child Protection plan in place? |
| Is the child looked after? Name of Social Worker: |

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| **2. SETTINGS ATTENDED**  |
| Early Years Provision/School Attending: |  |
| Number of Sessions per week (days / am / pm):   |  |
| Key Stage: FS/KS1/KS2/KS3 |  |
| Address: |
| Postcode: | Tel No: |
| Keyworker/Class teacher: | SENCo: |
| Email address: |

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| **3. MEDICAL INFORMATION** |
| GP Practice: |
| Any change to medical history:*e.g. hearing status/tests, diagnoses, etc.*  |
| Dummy used until the age of: |

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| **4. REASON FOR RE-REFERRAL** |
| Please describe what has changed since previously seen and the child’s current needs:* *Please provide a brief explanation of intervention since last seen by Speech and Language Therapy, what has been delivered, how often, etc.*
* *Please describe any new concerns, has the child achieved/not achieved previous targets?*
* *Include any other changes or updates that may be relevant to the child’s speech, language and communication needs.*
* *Please attach relevant supporting information e.g. speech screen, most recent APDR documentation.*
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| **4. OTHER RELEVANT INFORMATION**  |
| Does the child have difficulty with other skills / areas of development e.g. learning, cognition, medical, emotional, behaviour and social skills?  |
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| Is the child known to any other agencies? e.g. paediatrician, educational psychology, CAMHS. Does the child have an EHCP? |
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| **5. REFERRER’S DETAILS** |
| Referrer’s Name: | Profession: |
| Contact Address: |
| Postcode: | Tel No: |

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| **6. CONSENT FOR REFERRAL** |
| Referral to Speech and Language Therapy must be discussed with the parent / carer, and verbal consent gained. Please ensure the following is completed |
| Does the carer know their child may be discharged if they fail to attend their initial appointment without notification? | [ ]  Yes [ ]  No |
| Signature of Referrer\*: | Date: |
| Signature of Carer: | Date: |
| We are unable to accept the referral without consent from a person with parental responsibility \*For early years referrals verbal consent can be gained  |

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| **8. RETURN TO:**  |
| **Health visitor and Systm1 users should refer using electronic referral processes** Please save a copy of these forms for your own records and send originals to:-Speech & Language Therapy ServiceNew Beacon HouseRidge WayScunthorpeDN17 1AJTel: 01724 203755nlg-tr.NLChildrensTherapyTeam@nhs.net |