|  |
| --- |
| **Admin use only** |
| Date received |  |
| Therapist |  |

 **Specialist Children’s Services**

**SPEECH AND LANGUAGE THERAPY REFERRAL FORM**

Reception – 19 years old

(for all preschool children, and in the Hambleton and Richmondshire area children aged up to 4 years 11 months, please attend a drop-in clinic)

**CHILD INFORMATION**

Child’s Name………………………………………………… (M/F) Date of Birth……………………..………..

Name of Parents/Carers………………………………………...………………………………………………………………

Address……………………………………………………………………………………………………………………………

Preferred contact number……………………….……………… Email address……………………………………………..

G.P…………………………………………..…Has child’s hearing been checked? If so, when? ………….…………….

Languages spoken at home…………………………………………………………………………………………………….

Interpreter required (telephone) Yes No

Known diagnosed medical conditions or developmental concerns…………………….………………….………………..

**SCHOOL INFORMATION**

School………………………….. Class Teacher………………… Teaching Assistant…………..………Year Group….

Code of Practice (please tick as appropriate)

 Can-Do My Support Plan – Date……..……. EHCP/statement – Date………..……………

n

Comments: ………………………………………………………………………………………………………………………

Teacher rated levels for:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **English (reading)** | ✓ |  | **English (speaking & listening)** | ✓ |  | **Maths** | ✓ |
| Ahead of age expected level |  |  | Ahead of age expected level |  |  | Ahead of age expected level |  |
| Within expected level |  |  | Within expected level |  |  | Within expected level |  |
| Below expected level |  |  | Below expected level |  |  | Below expected level |  |
| Significantly below expected |  |  | Significantly below expected |  |  | Significantly below expected |  |

Other professional involvement (e.g. EMS, Educational Psychology, Hearing Support, Occupational Therapy, Healthy Child Team, Prevention Team, IES / C & I Network

………………………………………………………………………………………………………………………………………

Has the child previously been seen by the Speech and Language Therapy Service or attended a Speech and Language Therapy Drop-In session? YES NO If yes, please give details……….……………..……

**ESSENTIAL REFERRAL INFORMATION**

Main speech and language concerns (please complete guidance form, and if appropriate attention and listening screen or speech sound screen, and attach with referral):

|  |  |  |
| --- | --- | --- |
|  | ✓ |  |
| Understanding spoken language |  | Children in **key stage 2 and above** who present with social communication needs should be referred to Inclusive Education Services via the Single Point of Access before being referred to Speech and Language Therapy. They will then refer to Speech and Language Therapy, if appropriate.[http://www.northyorks.gov.uk/article/28840/SEND---specialist-support-and-provision-in-North-Yorkshire](https://owa.hdft.nhs.uk/owa/redir.aspx?SURL=uqE1ynF-SAK33_HWvfg6TrNya3gbPa70j4bE0vBEdC7x2Sqa9DXTCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBuAG8AcgB0AGgAeQBvAHIAawBzAC4AZwBvAHYALgB1AGsALwBhAHIAdABpAGMAbABlAC8AMgA4ADgANAAwAC8AUwBFAE4ARAAtAC0ALQBzAHAAZQBjAGkAYQBsAGkAcwB0AC0AcwB1AHAAcABvAHIAdAAtAGEAbgBkAC0AcAByAG8AdgBpAHMAaQBvAG4ALQBpAG4ALQBOAG8AcgB0AGgALQBZAG8AcgBrAHMAaABpAHIAZQA.&URL=http%3a%2f%2fwww.northyorks.gov.uk%2farticle%2f28840%2fSEND---specialist-support-and-provision-in-North-Yorkshire) Referrals sent without involvement from Inclusive Education Services cannot be accepted. |
| Using spoken language (e.g. vocabulary, grammar) |  |
| Social communication / interaction with others |  |
| Speech sounds |  |  |
| Stammering |  |  |
| Eating and drinking |  |  |

**Please provide specific details of current support in school and attach any written evidence (e.g. school and/or individual provision map, information from Inclusive Education Services, details of staff trained in ELKLAN, use of Let’s Communicate DVD series etc):**

|  |  |
| --- | --- |
| **UNIVERSAL PROVISION**Quality First Teaching(see attached guidance) |  |
| **TARGETED PROVISION*** Early Intervention

Additional interventions eg: narrative |  |
| **SPECIALIST PROVISON*** Personalised provision
 |  |

**CONSENT**

Parents/Carers have agreed to this referral and:

* reports and recommendations being shared with and from relevant professionals
* their child being seen in school
* video/audio recordings of their child being made for speech & language therapy assessment purposes only
* Speech and Language Therapy students may work alongside the Speech and Language Therapist

**NB: Please cross out any of the above which you do not wish to give consent to**

Signature of Parent/Carer ……………………………………………… Date……………………………………..

**REFERRAL BY SENCO ONLY**

Name………………………………………..………………………... Date of Referral……………………….……………

Address……………………………………………………………………………………………………………………………

Tel No…………………Email Address……………………………………… Signature………………………………………

**Please send to your local Speech and Language Therapy Department**

|  |  |
| --- | --- |
| **Harrogate and District**Child Development CentreHarrogate District HospitalLancaster Park RoadHarrogate HG2 7SX | **Hambleton and Richmondshire**Speech and Language TherapyGibraltar HouseThurston RoadNorthallerton DL6 2NA |