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|  **Specialist Children’s Services** |

**Pre-School Speech and Language Therapy**

**Referral Form**

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| **Child’s name:** |  | **GP:** |  |
| **Child’s DOB:** |  | **Health Visitor:** |  |
| **Address:**  |  | **Pre-school/Nursery:** |  |
| **Telephone number:** |  | **Parent/Carers names:** |  |
| **Mobile number:** |  | **Email address:** |  |
| **We will not be able to process this referral without a current email address** |
| **What concerns do you have regarding your child’s speech, language or communication development?**  |
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| **Has your child ever had Speech and Language Therapy before? Yes No****Is there a family history of Speech, Language or communication needs? Yes NO** |
| **If yes, please give more details:** |
| **What languages are spoken at home?** |  |
| **What age did your child reach the following milestones?** |
| **Sit** |  | **Walk** |  |
| **Say 1st word** |  | **Put words together** |  |
| **Does your child: (please tick all that apply)** |
| **Wave** |  | **Look at you** |  | **Point** |  |
| **Babble**  |  | **Smile** |  | **Shake their head “no”** |  |
| **Show you toys/objects** |  | **Pull you to an object** |  | **Say single words** |  |
| **Use a dummy** |  | **Suck their thumb** |  | **Put words together** |  |
| **Has your child ever had any feeding difficulties? YES NO** |
| **If yes, please give more details:**  |

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| **Has your child had ear infections in the past? YES NO** |
| **When was their last hearing test?** |  |
| **How does your child interact with others? What types of play do they engage in?** |
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| **Are there any other professionals involved with your family? E.g. Social worker, family outreach support worker (FOSW)** |
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**PLEASE COMPLETE THE FOLLOWING QUESTIONS RELATED TO YOUR CONCERNS:**

(Tick the statements that best describe your child)

**Listening and Attention:**

□ Fleeting – they move between activities quickly

□ Rigid – they concentrate on a task of their own choice but cannot tolerate interruption by an adult

□ Single Channelled – they can only attend to one activity at a time

□ Focusing attention – they can shift their attention from one activity to another when asked

□ Two channelled attention – they can do a task and listen to an instruction

□ Integrated attention – they can attend to tasks in different situations with different people

**How do you get the child’s attention? (Call name, physical prompt, gesture) ­­­­­­­**

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**Expressive Language - What does your child say?**

□ My child doesn’t say any words.

□ My child says single words. If so, how many (approximately) ……..

□ My child puts 2 words together e.g. Mummy more, juice please.

□ My child puts 3 words together e.g. Mum more juice.

□ My child puts a short sentence together.

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 **Please give examples of what the child is saying (single words, phrases, requests, repeating what adults say).**

**Following instructions:**

□ My child doesn’t follow instructions.

□ My child follows simple instructions e.g. find your shoes.

□ My child follows longer instructions e.g. where's mummy's coat?'

**Speech sounds:**

□ My child is easy to understand.

□ I understand what my child is saying, but others don’t

□ Adults who are frequently around my child can understand what my child is saying

□ Adults who are not frequently around my child can understand what my child is saying

□ I’m worried about my child’s pronunciation of speech.

**Stammering:**

**When did your child start to stammer?**

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**Does anything change the frequency of your child’s stammer? *E.g. what makes it harder/easier for them to talk?***

**How aware is your child of their stammer?**

□ My child is not aware of their stammer.

□ My child is becoming aware of their stammer.

□ My child is very aware of their stammer.

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| **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/nursery
* 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…………………………………….. |

**REFERRER INFORMATION**

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| Name of referrer: | Date of Referral: |
| Relationship to the child: |
| Address: |
| Email Address |
| Contact phone number: |
| Signature |

Please send a completed copy of this referral form to: hdft.scsadmin@nhs.net or send to:

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| **Harrogate and District**Child Development CentreHarrogate District HospitalLancaster Park RoadHarrogate HG2 7SX | **Hambleton and Richmondshire**Speech and Language Therapy Child Development Centre 24 Brompton RoadNorthallerton, DL6 1EA |