**SPEECH AND LANGUAGE THERAPY REFERRAL FORM FOR MAINSTREAM SCHOOLS**

**All Community Paediatric referrals must be directed to the Care Co-ordination Centre**

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| C:\Users\fiona.hamilton.GREEN\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\AY0NO28M\mail-envelope-exterior-icon-2877-medium[1].png | Care Co-ordination Centre, Constantine House, Constantine Road, Ipswich, IP1 2DH |
| **🕿** | **0300 123 2425** |

**Please refer to the** [**Referrals Guidance available**](http://www.suffolkcommunityhealthcare.co.uk/OurServices/ChildrensServices/Referrals.aspx) **to ensure your referral meets the service criteria.**

**Incomplete referral forms and those with insufficient information will be returned.**

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| **Patient Information** |  | **Referrer & GP Information** |
| **Name** |  |  | **Referrer** |  |
| **NHS No** |  |  | **Referring Org** |  |
| **Patient Address** |  |  | **Organisation Address** |  |
| **Tel (Home)** |  |  | **Referrer Tel** |  |
| **Tel (Mob)** |  |  | **GP Practice** |  |
| **DOB** |  |  | **Usual GP** |  |
| **Gender** |  |  | **Referral Date** |  |

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| **Parent/Carer Information** |
| **Name/s:** |  | **Home Tel No:** |  |
| **Work Tel No(s):** |  | **Mobile(s):** |  |

**PLEASE NOTE:**

1.  **If you are referring following a Language Link or Speech Link screen, please go straight to section D.**

**2. If you are referring for concerns regarding stammering, voice, eating/drinking or unintelligible speech, please fill in section A and then skip straight to section F.**

**If neither of the above applies, please complete the whole form**

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| 1. **Reason for Referral**

*Please include full details. Additional information may be required which is outlined in the* [*Referrals Guidance*](http://www.suffolkcommunityhealthcare.co.uk/OurServices/ChildrensServices/Referrals.aspx)*.* *Please note all referrals will be triaged by a senior clinician and response times/urgency assigned according to priority.*  |
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| 1. **What screening tool have you used to assess the child’s speech and/or language?**

*NB: You must show evidence that you have screened a child before a referral can be accepted (e.g. Well comm; Universally Speaking (Communication Trust))* |
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| 1. **What intervention have you done following this screen?**

*Please comment on the type of intervention given, the number of sessions and how successful it was for the child.* |
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| 1. **If you have administered a Language Link or Speech Link screen, please write in the pupil number in the box below.**
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| 1. **Please use this box to include any other information (including that which we would not be able to see through viewing the Language Link and Speech Link assessment data).**

*e.g. concerns with attention and listening, expressive language, social communication etc.* |
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| 1. **Relevant Past Medical History** (if known):
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| 1. **Social History/Safeguarding Concerns / CAF / TAF / Child in Care** (including any special considerations/issues to be aware of when visiting)**:**
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| **Name and contact details of social worker involved:** |
| 1. **Date and result of last hearing test (where relevant):**

**NB:** *Any observation of discharge, perforation or occluding wax (after treatment) should be referred directly to ENT* |
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| **Other Agencies/ Professionals involved with this child / young person, i.e. Consultant(s)/Health Visitor/Social Worker/Dietician:** |
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| **Child’s first language:****Parent/Carer’s first language:****INTERPRETER REQUIRED:** |
| **Consent:** *Please sign below to indicate that you have explained this referral to the young person/parents/carers and that you have gained their consent for this referral to be considered.  This may involve an internal multi-disciplinary discussion, to ensure that if accepted the referral will be directed to the most appropriate service/s.* **Name:****Date:** |