

For SLT Commissioning Schools / Nurseries Only Initial assessment to be at: **CoCHC / In School**
(Please delete as appropriate)

CHILDREN'S SPEECH & LANGUAGE THERAPY REFERRAL FORM (Communication only)

CHILD'S NAME: DOB: NHS No:

NAME OF REFERRER: DESIGNATION:

REFERRAL DATE: REFERRER PHONE NO:

REFERRER ADDRESS:

For swallowing and feeding concerns please use our Speech and Language Swallowing and Feeding (Dysphagia) referral form

A referral will be accepted for children under 18 months of age for:

- Moderate - Severe bilateral sensori - neural hearing loss (up to the age of 3 years)
- Cleft palate (up to the age of 3 years)
- Acquired brain injury (occurred in the last 12 months)

A referral will be accepted for children over 18 months of age for:

- Pre 30 week gestation (up to the age of 3 years.)
- Looked After Child with communication difficulties
- Medical condition / syndrome with known related severe speech and language difficulties
- Referred by Consultant Paediatrician
- Voice difficulties (must have been assessed by Ear, Nose & Throat Consultant)
- Child/Young Person attends a setting that commission a Speech and Language Therapy service from CWPT

- A referral will be accepted for children who have concerns around speech sound development or stammering from 2 ½ years old**

All other children referred must be over 2 years old and have received a period of intervention for a minimum of 3 months (e.g. additional support from health visitor / teaching assistant)

Has the child been given a period of intervention for a minimum of 3 months?

Yes

No

Please answer the following questions: -

Please provide a period of intervention for 3 months and refer if concerns remain

What type of intervention has been provided?.....
.....

What progress has been made?.....

How long has the intervention been provided for?.....

If the child does not meet the criteria above a referral cannot be accepted

Simon Gilby - Chief Executive

PLEASE ENSURE THAT THIS FORM IS FILLED IN FULLY. IT WILL BE RETURNED TO YOU IF ITEMS ARE NOT COMPLETED.
PLEASE CROSS OUT ANYTHING THAT IS NOT APPLICABLE
HEALTH PROFESSIONALS ARE ONLY REQUIRED TO FILL OUT NAME, DOB, NHS NUMBER & EDUCATION SETTING

CHILD'S DETAILS	Sex: M F	PARENT / CARER 1:	PARENT / CARER 2:
Date of Birth:		First Name:	First Name:
NHS Number (if known):		Surname:	Surname:
First Name(s):		Relationship to child:	Relationship to child:
Surname:			
Address:	Address (if different from child)	Address (if different from child)	
.....	
Postcode:	Postcode:	Postcode:	
Telephone:	Telephone:	Telephone:	
Email address:	Holds parental responsibility? Yes / No	Holds parental responsibility? Yes / No	
	If no, please provide details of who does hold responsibility:	If no, please provide details of who does hold responsibility:	
	

GP:	Nursery / School:
Address:	Teacher's Name:

Language(s) spoken by child:

Language(s) spoken by parent/carer:

Interpreter needed for parent Y N or child? Y N

Length of time the child has been exposed to English?

Are there concerns about the child's understanding and use of their home language? If yes, please give details;

.....

Religion:

Ethnic Origin (Please tick)

<input type="checkbox"/>	White British	(A)
<input type="checkbox"/>	White Irish	(B)
<input type="checkbox"/>	Other White	(C)
<input type="checkbox"/>	White & black Caribbean	(D)
<input type="checkbox"/>	White & black African	(E)
<input type="checkbox"/>	White & Asian	(F)

<input type="checkbox"/>	Other mixed	(G)
<input type="checkbox"/>	Asian- Indian	(H)
<input type="checkbox"/>	Asian- Pakistani	(J)
<input type="checkbox"/>	Asian- Bangladeshi	(K)
<input type="checkbox"/>	Other Asian	(L)
<input type="checkbox"/>	Black Caribbean	(M)

<input type="checkbox"/>	Black African	(N)
<input type="checkbox"/>	Other Black	(P)
<input type="checkbox"/>	Chinese	(R)
<input type="checkbox"/>	Other Ethnic group	(S)
<input type="checkbox"/>		
<input type="checkbox"/>	Not stated	(Z)

Known / referred to other Professionals;
(please tick)

- | | | |
|---|---|--|
| <input type="checkbox"/> Audiology | <input type="checkbox"/> CAMHS | <input type="checkbox"/> SEND Early Years |
| <input type="checkbox"/> CIASS | <input type="checkbox"/> Educational Psychology | <input type="checkbox"/> Early Support |
| <input type="checkbox"/> LAWSS | <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Neurodevelopmental Team |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Medical Consultant / Paediatrician | <input type="checkbox"/> Other (please specify) |

Known to Social Care? Y N Does the family have a CAF? Y N CAF Level

Named Social Worker and Base: CAF Lead and Base:

Does the child have a Statement / EHCP? Y N

Relevant child & family, developmental and medical history (e.g. learning, hearing, visual, mobility, mental health, medical diagnosis, behavioural difficulties):

.....

PLEASE TELL US ABOUT THE CHILD'S DIFFICULTIES & GIVE EXAMPLES:

1) Understanding e.g. following instructions		6) Voice e.g. hoarseness NB. Needs ENT referral	
2) Use of Language e.g. using words and sentences		7) Social communication e.g. eye contact, turn taking	
3) Speech e.g. saying words clearly		8) Other e.g. cleft palate, hearing impairment	
4) Stammer/Stutter		9) Behaviour	
5) Attention/Listening		For swallowing and feeding concerns please use our Speech and Language Swallowing and Feeding (Dysphagia) referral form	

What would you like to achieve from this referral?

.....

We will share information with other health professionals as appropriate		
<u>I give consent</u>		
• to an assessment by the Speech and Language Therapy Service as appropriate for my child	Yes	No
• for my child to be seen in school/nursery (face to face or virtually) even if I am unable to be present	Yes	No
• for my child to be seen by a SLT student under the supervision of a qualified SLT	Yes	No
• for information to be shared with other professionals (inc. local authority)	Yes	No
• for information to be communicated between any independent speech and language therapists (SLTs) who are involved with my child and the NHS SLT service	Yes	No
• for my child to be photographed / videoed for clinical purposes	Yes	No
• for staff at my child's nursery/school/other professionals to request further appointments for my child on my behalf	Yes	No
• to be contacted via:		
* email	Yes	No
* text message	Yes	No
* voice mail messages	Yes	No
Signed: (Parent/guardian) Print Name:.....		
Date:		



You can access our website for general information and waiting times at the following address
www.coventrychildrenssl.co.uk

Please note: referrals will only be accepted if the child or young person is registered with a Coventry GP

Please return to:

Children's Speech and Language Therapy Service
Paybody Building
C/O City of Coventry Health Centre
2 Stoney Stanton Road
Coventry
CV1 4FS

Telephone: 024 76961455

Additional Information for school aged children only

EDUCATION PROFILE

How well is this pupil achieving compared to their peers. Please complete the tables below.

	Well below average	Below average	Average	Above average	Well above Average
Reading ability					
Writing ability					
Spelling ability					
Maths ability					

COMMUNICATION PROFILE

	Major problem – achieves less than 50% of the time	Medium problem – achieves 50% of the time	Minor problem – achieves 70% of the time	No problem – achieves 90% of the time
Attention				
a) Attention in class				
b) Attention in small group				
c) Attention in 1:1 situation				
Receptive language				
a) Following class instructions				
b) Following group instructions				
c) Following 1:1 instructions				
d) Understanding curriculum vocabulary				
e) Understanding everyday words				
f) Responding appropriately to questions				
g) Understanding a story				
h) Following class routines				
i) Following sequenced instructions				
Expressive language				
a) Using appropriate vocabulary				
b) Using appropriate sentences				
c) Ability to ask for help				
d) Ability to give explanations				
e) Ability to ask questions				
f) Ability to retell a simple story				
Speech (Clear pronunciation)				
a) Spoken single words				
b) Spoken sentences in context				
c) Spoken sentences when context not known				
d) Phonological Awareness / phonic skills				
Fluency				
a) Speed of spoken language				
b) Ease of talking				
c) Confidence to talk				
Voice (e.g. hoarse / high or low pitch)				
a) Quality of voice production				
Social communication (pragmatics)				
a) Eye contact				
b) Behaviour in social situations				
c) Taking turns				
d) Conversation skills				
e) Playground behaviour				
f) Understanding abstract language e.g. idioms/jokes/sarcasms (8yrs + only)				
g) Understanding emotions of others				
h) Expressing own emotions				

Additional Information

Please use this space to provide details of any other communication concerns or observations