NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

# SPEECH AND LANGUAGE THERAPY REFERRAL FORM

**PLEASE NOTE: A referral can only be accepted if ALL sections are completed and written consent from the parent/carer with parental responsibility for the child is included (unless referrer is a health professional.) INCOMPLETE FORMS WILL BE RETURNED. Please attach parental consent letter. You may wish to take a photocopy of the referral form for your own records.**

Name of Child …….M / F Date of Birth …..…../…...…./……..

Address …….

Post Code ……..NHS Number (Health Professionals Only) …….

Telephone (please circle preferred daytime contact number):

Home …… ……Mobile …..……Work……

Are Parents / Carers happy to be contacted by text message? (please tick) YES….. NO…..

Name of Parents / Carers……

Do Parents / Carers have any literacy difficulties? YES..... NO…..

Languages spoken in the home …… Interpreter needed? YES…. NO….

G.P:
Name……..Address……..……..

Health Visitor / School Nurse:
Name……..Address…….……

Name of Pre-School / School……..……

Are there any current safeguarding concerns? YES….. NO……

If yes, please give details as appropriate…….

| **Other Specialist Services Involved:** | **Name of Service/Professional Involved:** |
|---|---|
| Educational Psychologist | |
| Education Support Services (e.g. Link Teacher, Teacher of the Deaf, Outreach Support etc…) | |
| Community / Consultant Paediatrician | |
| Other Specialist Health Services (e.g. Physiotherapy, Occupational Therapy etc…) | |
| Children's Hearing Service | |
| PCMHT / CAMHS | |
| Social Services | |
| Other Services Involved | |

**REASON FOR REFERRAL**

| Please tick which areas the child is experiencing difficulties with: | | Please Comment how these difficulties are affecting the child: |
|---|---|---|
| | Attention and listening skills | |
| | Early communication skills (e.g. turn taking, play, eye contact, pointing etc…) | |
| | Child's understanding of spoken language | |
| | Ability to use language (e.g. speech, signs, symbols, communication aids etc…) | |
| | Clearness of speech | |
| | Social interaction skills | |
| | Stammering | |
| | Eating and/or drinking skills | Please complete additional information sheet |

| |
|---|
| Does this child's ability to communicate differ from their abilities in other areas? |
| What strategies or techniques have you tried to overcome these difficulties? |
| What was the result of these? |

**FOR HEALTH VISITORS/COMMUNITY NURSERY NURSES ONLY:**

**Please add the results of your Wellcomm Tool screen if carried out:**

| Section the child scored green | Any relevant information |
|---|---|
| | |

**If the Wellcomm Tool was not carried out, please fill in the table below for reason:**

| | Please tick |
|---|---|
| **The child is not in the 2- 2 ½ year age range** | |
| **The child is being referred for stammering/selective mutism/unintelligible speech/social communication issues** | |
| **The child was unable to comply with direct assessment** | |

**Parents informed of referral to Speech and Language Therapy (essential)**

- ☐ **Verbal consent if a health professional**
- ☐ **Written parental consent form completed and attached if education / other professional**

**REFERRAL MADE BY**

**Name (print) …… Signature…….**

**Job Title……**

**Base / Address……**

**…… Post Code: ……..**
**(Please complete with full address and postcode)**

**Tel No……** **Date of referral ……../…..…./……....**

# ONLY COMPLETE THIS PAGE IF THERE ARE ANY EATING AND DRINKING CONCERNS

**Please tick yes / no in all boxes as applicable to the child being referred for eating and drinking difficulties**
**Please note the referral will not be processed if form is not completed.**

| **During Feeding** | **YES** | **NO** |
|---|---|---|
| Child coughs/chokes during feed<br>solids and liquids:<br>liquids only: | | |
| Child frequently clears throat during/after feed | | |
| Child becomes red in face during feed | | |
| Eyes water during feed | | |
| Refuses some/all of feed | | |
| Vomit all or some feed | | |
| | | |

| **Respiratory Difficulties** | **YES** | **NO** |
|---|---|---|
| Suffers from recurrent chest infections | | |
| Suffers from recurrent bouts of pneumonia | | |
| Has wheezy/gurgly sounding breathing | | |
| Does child suffer from asthma? | | |

:

| **Reflux** | **YES** | **NO** |
|---|---|---|
| Does child suffer from asthma? | | |
| Is he/she on any anti-reflux medication, if so please name | | |

| **Weight** | **YES** | **NO** |
|---|---|---|
| Has the child lost weight? | | |
| Is the child underweight? | | |
| Are you concerned over rate of weight gain? | | |

| **Additional Information** | **YES** | **NO** |
|---|---|---|
| Does the child tire easily (particularly during feeds) | | |
| Does the child appear lethargic/listless | | |
| Does the child have a naso–gastric tube | | |
| Does the child have a gastrostomy fitted? | | |
| Does the child have any oral intake | | |

**<u>Position/Seating</u>**

Please state normal seat/position in which child fed, e.g. on parent's knee, high chair, specialist seating/standing frame etc.

| |
|---|
| |

**Please forward the referral forms to:**
**Speech & Language Therapy, The Bungalow, Longshoot Health Centre, Scholes, Wigan, WN1 3NH Tel: 01942 483613/4**

# Parent / Carer Consent Form for Referral to the Speech and Language Therapy Service

(***Please note written consent must be obtained from the parent/carer with parental responsibility for the child)***

Date……/……..……/……..

Dear ……

I would like to refer …….. to the Speech and Language Therapy Service.

In order to do this written parental permission is required.

Please complete the details below and return to Nursery / School.

Yours sincerely,

**Parent / Carer Consent with parental responsibility for the child**

- I give consent for my child …… to be referred to the Speech and Language Therapy Service
- I give consent for the Speech and Language Therapist to liaise and consult with other people involved with my child
- I give consent for the Speech and Language Therapist to share information with other services involved with my child

**Parent / Carer Name (Print)…….**

**Signature……..**

**Relationship with child……**

**Date……../……..…../……**