

**Nottingham and Nottinghamshire**

**Children’s Speech and Language Therapy (SLT) Services**

**Request for Support**

**(excluding Bassetlaw Specialist Services but including Home Talk)**

* The SLT service sees children with significant communication difficulties and eating and drinking difficulties. These questions will help us to decide whether we are able to accept the request and decide on the most appropriate therapist to support the child/young person.
* **Please use the referral checklist to support your referral and attach it to this Request for Support form when you refer.**
* **If this referral is for eating and drinking, please request a separate Eating and Drinking Referral Form and Checklist from the SLT service.**
* Please complete all appropriate sections and provide as much information as possible.
* If the child is in an education setting, the setting and parents should fill the referral in together so we can see everyone’s views and concerns.
* Referring agents other than Health Visiting or Schools teams, **such as GPs**, will need to liaise with relevant services to complete this request in order to provide the information required.
* **The request for support can only be accepted if this form is completed fully.** Where sections are not applicable, please indicate this by writing ‘N/A’.
* If this referral is for a young person 16 years old or over, the form needs to be filled in jointly with the young person.

SLT

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| **SECTION A. Personal Information** | | | | | | | | | | | | | |
|  |  | | | | |  | | |  | | | |  | |
| First Name |  | | | | | Surname/Family Name | | |  | | | |  | |
|  |  | | | | |  | | |  | | | |  | |
| Date of Birth |  | | | | | Gender | | |  | | | |  | |
|  | |
|  | | | | | | | *Please ask parent/carer to provide this:* | | | | | |  | |
| Hospital Number | |  | | | | | NHS No | |  | | | |  | |
|  |  | | | | |  | | | | | | | |
| Address |  | | | | | Postcode | | |  | | | |  | |
|  |  | | |  | | | |  | |
|  | | | | | | | | | | | | | |
| Parent/Carer  Name(s) and Contact Details | Name | |  | | | | | Parental Responsibility? | | | Yes | No |  | |
| Telephone Number | | |  | | | | Email Address | |  | | |
|  | |  | | | | |  | | |  |  |
| Name | |  | | | | | Parental Responsibility? | | | Yes | No |
| Telephone Number | | |  | | | | Email Address | |  | | |  | |
|  | | | | | | | | | | | | | |
| Name & contact details of person/body with Parental Responsibility, **if different from Parent/Carer**: | | | | | |  | | | | | | |  | |
|  | | | | | | | | | | | | | |
| Ethnicity |  | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | |
| Religion |  | | | | Immigration Status  (e.g. permanent, asylum seeker) | | | |  | | | |  | |
|  |  | | | | How long have they lived in the UK? | | | |  | | | |  | |

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| **SECTION B. SLTs recognise bilingualism as an advantage. We use interpreters and our own bilingual staff to help us assess children’s skills in all languages they use, and that other people use with them.** | |
| Language(s) used to speak to the child/young person |  |
| Language(s) used by the child/young person |  |
| Any other language(s) and/or dialect(s) used at home |  |
| Do parents require an interpreter? State language and/or dialect. |  |

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| **SECTION C. Referer Information** | |  |  | |
| Name of Referrer | | Role | |
|  |  |  |  |
|  | Contact address | Contact number |  |
|  |  |  |  |
|  | Email address |  |
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| **SECTION D. Medical Conditions – Please provide details of any medical condition**  Does the child/young person have a medical condition / disability, and if so, do they have a diagnosis? | |
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| Date of Diagnosis |  |
| Diagnosing Agency |  |
| Further Details: e.g., medication, special requirements | |
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| **SECTION E. Family Information** | | |
| Has the child/young person been seen by SLT previously? | Yes | No |
| If yes, please give details (where and when last seen, reasons). | | |
| Are there concerns or indicators that the child may have autism or social communication difficulties? | | |
|  | Yes | No |
| If yes, please give details. | | |
| Has anyone else in the family had speech, language or communication difficulties? | | |
|  | Yes | No |
| If yes, please give details. | | |

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| **SECTION F. Hearing** | | | | | | |
| Do you think the child/young person may have difficulty hearing? | | | | Yes | | No |
| If yes, please give details. | | | | | | |
| Has the child/young person been referred for a hearing test? | | | | Yes | | No |
| Does the child/young person wear hearing aids? | | | | Yes | | No |
| If you have any concerns that the child/young person may have a hearing difficulty, please refer to children’s Audiology. | | | | | | |
| Does the child/young person have hearing loss? | | | | Yes | |  |
| If yes, please indicate. | | | | | | |
| Mild  (21-40db) | Moderate  (41-60db) | Moderate- Severe  (61-70db) | Severe  (71-90db) | | Profound  (>90) | |
| Date detected: | | | | | | |

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| **SECTION G. Speech Language and Communication information**  Use the boxes below to describe your concerns. Put N/A if there are no concerns in a particular area.  For bilingual children, please state which language the concerns relate to.  Please complete BOTH parent/carer and setting/referrer views. | |
| **Parent/carer views** | **Setting/referrer views** |
| Attention & Listening  (How well can they concentrate on other people and activities? Do they need help to focus/refocus their attention? How long can they concentrate on a task for?) | |
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| Understanding Spoken Language  (Including following instructions, answering questions, following the routine - please give examples) | |
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| Using spoken language  (Do they use words to communicate what they want? Include information about putting words together, talking in sentences, telling stories – please give examples) | |
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| Speech Sound Development  (i.e., list of sounds that are difficult to say; general intelligibility; specific tricky sounds - please give examples of how your child pronounces words) | |
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| Stammering  (How long they have been stammering? Are they aware? Are there sound repetitions/prolongations/getting stuck?) | |
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| Social Interaction and Play  (e.g.. How do they interact, play and talk to other children and adults? Do they enjoy playing with other children?) | |
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| What are you most worried about? How long have you been concerned?  (Please describe) | |
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| How does it affect them daily? | |
|  |  |
| How have you tried to help? | |
|  |  |
| What support do you want from SLT? | |
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| Completed by:  Relationship to child: | Completed by:  Relationship to child: |

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| **SECTION H. Involved Professionals – Please provide details of any involved support services (from health and education).** | | | | | | | | | |
| **GP Details:** | | | | | | | | | |
| **Current Education/Childcare Placement:** | | | | | | | | | |
| e.g., playgroup, nursery (private/independent), child minder, mainstream school etc.  If the child/young person attends more than one setting, please give details for main placement. Indicate the days and times attended. | | | | | | | | | |
| Name of Placement | |  | | | | | | | |
| Address | |  | | | | | | | |
| Key Contact | |  | | | | | | | |
| Attends on: | Monday | | Tuesday | | Wednesday | | Thursday | | Friday |
| Any additional information regarding attendance: | | | | | | | | | |
| **Any Safeguarding concerns?** | | | | Yes | | No | | Not known | |
| If yes, please specify with details of Social Worker if known. | | | | | | | | | |
| **Any Special Education needs?** | | | | Yes | | No | | Not known | |
| If yes, please specify. | | | | | | | | | |
| Does the child/young person have an Education, Health and Care Plan (EHCP)? | | | | | | | | | |
|  | | | | Yes | | No | | Not known | |
| **Attach additional relevant information:**  e.g., School-based assessments, recent reports, medication, relevant investigations | | | | | | | | | |
| Other documents attached? | | | Yes | | | | No | | |
| **Have you asked anyone else for support?** | | | | | | | | | |
| **Any other information you feel may be useful:** | | | | | | | | | |

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| **SECTION I. Consent – Please complete with parents / carer or young person over the age of 16 at time of referral** | | | | | | | |  |
| I confirm that I have discussed my concerns with the parent/ carer/ young person  Yes / No | | | | | | | | |
|  | | | | | | | | |
| ***Does/has the parent/care / young person: -*** | | | | | | | **Please tick:** | |
| Agree to their child/young person being referred to the service. | | | | | | |  | |
| Received information about what to expect following the referral from the referrer. | | | | | | |  | |
| Confirm that the information given on this referral form is correct. | | | | | | |  | |
| Consent to the child/young person undergoing assessment and treatment. | | | | | | |  | |
| Consent for the child/young person to be seen in school by a visiting therapist/nurse. | | | | | | |  | |
| Are aware that information regarding their child/young person, will be shared with other health, education, and social care professionals, which may include independent/external practitioners that are involved in their child/young person’s care. | | | | | | |  | |
| Gives permission for the service to access their child’s electronic healthcare records. | | | | | | |  | |
| Understand that they will be contacted to opt-in and book an appointment, where applicable. | | | | | | |  | |
| Consent to letters/appointments being sent by email. | | | | | | |  | |
| Consent to being contacted by SMS text messages regarding appointments. | | | | | | |  | |
| Consent to voicemail should a message need to be left by the service. | | | | | | |  | |
| Consent to their child/young person being filmed/photographed for clinical use. | | | | | | |  | |
| Understand that consent is enduring and if they wish to withdraw consent at any time, or if anything changes, they can do so by contacting the team on the number below. | | | | | | |  | |
| **Parents/carers are able to opt out of receiving SMS text messages and/or voicemails from the service at any time by calling 0300 123 3387.** | | | | | | | | |
| **Please note it is the responsibility of the person with parental responsibility to let us know of any changes in contact details. By consenting to this referral, they agree for the service to use these methods of correspondence.** | | | | | | | | |
|  | | | | | | | | |
|  | Name of accountable professional |  | | Date |  | | |  |
|  | Signature of parent/carer at opt in or first visit |  | | Date |  | | |  |
|  | | | | | | | | |
| Are there any safety issues for a professional making a home visit alone?  (e.g., violence/aggression, aggressive dog, etc.) If yes, please provide details: | | | Yes | | | No | | |
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| **On completion of this form please make a copy for your own records and return as follows:**   * **Health professionals (only) and Education settings:** [childrensslt@nottshc.nhs.uk](mailto:childrensslt@nottshc.nhs.uk)  This must be encrypted using your education setting password, which has been provided by CCYPS. * **Parents/Carers:**   Speech and Language Therapy Referrals Admin  Children's Development Centre,  City Hospital Campus,  Hucknall Road,  Nottingham  NG5 1PB  Tel: 0300 123 3387 option 2  **We aim to notify you of the outcome of the referral within 2 weeks of receipt.** |