**Paediatric Speech and Language Therapy Service**

**Referral Form**

**(Southend, Castle Point, Rochford & Rayleigh areas)**

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| **Patient/Client details**: | NHS Number: |
| Surname: | Mr/Mrs/Master/Miss/Ms |
| First Name : | Male/Female/Non binary |
| Address: | Date of Birth: |
| Post code: | Age: |
| Telephone Number(s): | School/Pre School (if applicable):  One Planning/Early Support process started  EHCP Play & Parenting referral made  Section 23 referral made EHCP in place |

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| **Next of Kin details:** | Ethnic Origin: Religion: |
| Name: | First Language of parents: of child: |
| Relationship: | Will an interpreter be needed? For parents For Child |
| Email address: | Additional language(s) used: Will letters need translation |

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| **G.P details:** | **Hospital details** |
| Name: | Consultant ( if applicable ): |
| Surgery Address:  Telephone: | Unit Number ( if applicable): U533612 |
| Other agencies: | Name of Social Worker Involved: |
| **PLEASE SEE GUIDANCE NOTES OVER THE PAGE BEFORE FILLING THIS SECTION IN** | |
| **Please signpost to SLT website:**[**https://eput.nhs.uk/our-services/essex/south-east-essex-community-health-services/childrens/speech-language-therapy**](https://eput.nhs.uk/our-services/essex/south-east-essex-community-health-services/childrens/speech-language-therapy)    **Any relevant medical diagnosis?**  **Parent/carers description of communication concern and IMPACT this is currently having on the child**  **Referrers description of communication concern and IMPACT this is currently having on the child**  **Please explain what advice and support strategies you have given and checked are in place before making this referral**    **ASQ3 Summary Box (For Health Visitor use only) Date ASQ 3 completed:**  **Please fill out the relevant cut off scores for the child’s age and enter the relevant code from the key below to indicate;**  **N – Normal – no developmental concern based on ASQ 3 definition**  **C – Caution based on ASQ 3 definition**  **D- Delay based on ASQ 3 definition**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Area | Cut off | Total Score | 0 | 5 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 | 55 | 60 | | Communication |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | Gross motor |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | Fine Motor |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | Problem Solving |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | Personal-Social |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   **Client/Carer) consent to referral is required. Please note – This section MUST be completed and signed by the client/carer. Referrals will be returned if this is not signed**  **I have agreed to this referral**  **I have had the reasons for information sharing explained to me and agreed to the sharing of information with;**  **G.P Other Health Professionals (e.g. Health Visitor, School Health Advisor) School/Preschool SENCO’s**  **I AGREE TO TEXT ALERTS BEING SENT TO MY MOBILE PHONE TO REMIND ME OF AN APPOINTMENT**  **Signed …………………………………………………………… Name (please print) ……………………………………………..** | |
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| **Referrer details:** |  |
| Name: | Signed: |
| Address: | Professional Designation: |
| Telephone Number: | Date: |

**Please e-mail your referral to** [slt.educationenquiries@nhs.net](mailto:slt.educationenquiries@nhs.net) **or post to Hadleigh Clinic 49 London Rd, Hadleigh, Essex SS7 2QL**

**Paediatric Speech & Language Therapy Referral Form Guidance Notes**

**For Preschool Aged Children**

Referrals for preschool children are accepted from any health professional

All referrals from Health Visitors MUST include a completed Teddy Bear Kit and ASQ 3 screening assessment. If a referral is received without or with an incomplete Teddy Bear Kit and ASQ 3 it will be returned.

**For School Aged Children**

Referrals for children of school age are accepted from the school via an EHFSA or EHA form. Referrals for a school aged child without an accompanying EHFSA/EHA from will be returned.

**What Happens When The Service Receives a Referral?**

All referrals received by the service are screened by a Senior Speech & Language Therapist and a judgement is made as to whether they are accepted based only on the information provided on the referral form. Therefore, it is vital that specific information about the parental AND referrer concerns and impact on the child, is completed.

If sufficient information is provided on the referral the child or young person will either be allocated a triage or a full clinic assessment appointment.

Triage appointments are offered ONLY from selected local Children’s Centres and are 20 minutes in length. The service aims to offer a triage appointment from the closest geographical Children’s Centre to the child/young person’s home address.

Full clinic assessment appointments are up to 60 minutes in length. The service aims to offer a full clinic assessment appointment from the closest geographical clinic to the child/young person’s home address.

The Speech and Language Therapy service is unable to accept referrals for the following reasons;

* Feeding or swallowing difficulties
* Concerns about children learning English as an additional language (where home language is developing appropriately)
* Children who have speech, language or communication developing in line with their general learning skills.

Please ensure the following have all been completed/considered before submitting the referral:

* All sections have been signed (including the consent to referral from whoever holds parental responsibility for the child/young person)
* \*\*for looked after children, parental responsibility is likely to be held by the Local Authority. The Social Worker should be asked to sign consent on behalf of the LA not the foster carer\*\*
* A Teddy Bear Kit & ASQ 3 has been included with ALL Health Visitor referrals
* You have discussed with parents/carers and ensured they are committed to attend any appointments offered and you have listed any possible barriers to attendance for appointments offered.
* You have explained to parents/carers that failure to attend appointments offered will result in discharge from the service and no further appointments will be offered without a new referral to the service

**PLEASE EMAIL OR POST YOUR REFERRAL TO**

Hadleigh Clinic, 49 London Road, Hadleigh, Essex, SS7 2QL

Secure email [slt.educationenquiries@nhs.net](mailto:slt.educationenquiries@nhs.net)