**EPUT SEE Paediatric Speech & Language Therapy**

**Referral Form for School Aged Children**

**Guidance and Notes**

This form is to be used to make a referral to Paediatric Speech & Language Therapy in South East Essex, for all school-aged children. This includes 4 year olds in reception year up to 18 years of age.

The child must be living, and registered with a GP, in the South East Essex area (SS0, SS1, SS2, SS3, SS4, SS5, SS6, SS7, SS8 or SS9).

**Completion Notes**

* Please provide as much information as possible, where relevant, in order for clinicians to make a judgement on whether to accept the referral and what treatment pathway is required.
* A judgement is made based **only** on the information provided on the referral form. Therefore, it is vital that specific information is provided about the parental **AND** referrer concerns and impact on the child in both home and school settings.
* Referral forms that are not correctly completed, or with insufficient information, will be returned to the referrer to be updated and resubmitted.
* Once a referral is received by the SLT service, it will be registered for clinician review.
* If not accepted, the referral will be returned to the referrer with advice and any necessary action needed to resubmit or advice as to the most relevant service to signpost the referrer concern to. We aim to return unaccepted referrals within 2 weeks of receipt.
* If accepted, the child will be placed on a waiting list for either a triage or a clinic assessment appointment. The parent and referrer will be notified by letter and text when an appointment has been booked.
* Triage appointments are mostly offered via video consultation and are 20 minutes in length. We have limited capacity for face-to-face triage appointments if video consultation is not suitable.
* Clinic assessments are up to 45 minutes in length. The service aims to offer a clinic assessment appointment from the closest geographical clinic to the child/young person’s home address.

**The Speech & Language Therapy Service is unable to accept referrals for the following reasons;**

* Feeding or swallowing difficulties for children under 12 months old, or from any referrer other than Consultant or Specialist tertiary centre
* 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
* Concerns about social use of language skills without an underlying core language deficit

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

* Referral has been signed by referrer & 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 \*\*
* 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. Appointments will be offered during the school/working day and children are expected to attend.
* 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.

**Paediatric SLT Referral for School – Aged Children**

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| **Date of referral:** | Enter a date. |

**Referring agency details:**

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| Name of Referrer/ Lead professional: |  | Job Title: |  |
| Agency: |  | Address: |  |
| Tel/Mobile: |  | Email: |  |

**Family composition and details**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Include all those living in the family home** | | | | | | | |
| Young Person / Childs name | DOB | | Education Provision | | | Gender | Ethnic origin |
|  |  | |  | | |  | Choose an item. |
|  |  | |  | | |  | Choose an item. |
|  |  | |  | | |  | Choose an item. |
|  |  | |  | | |  | Choose an item. |
|  |  | |  | | |  | Choose an item. |
|  |  | |  | | |  | Choose an item. |
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|  |  | |  | | |  | Choose an item. |
|  |  | |  | | |  | Choose an item. |
|  |  | |  | | |  | Choose an item. |
| Parents/Carers name | | DOB | | Relationship to child | Parental responsibility? | | Ethnic origin |
|  | |  | |  |  | | Choose an item. |
|  | |  | |  |  | | Choose an item. |
|  | |  | |  |  | | Choose an item. |
| Family address  (including postcode) |  | | | | | | |
| Email address |  | | | | | | |
| Phone number(s) *Please list all numbers and whose number it is.* |  | | | | | | |

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| **Details of any significant people not living in family home** | | | | | | | | |
| Name | | Relationship | | Address *(including postcode)* | | | | |
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| **Further information about the family** | | | | | | | | |
| Child's first language |  | | | | Parent’s first language  *Is an interpreter required? If so, what language is preferred?* | |  | |
| Family Immigration Status | | |  | | | | | |
| Religion | | |  | | | | | |
| Details of any disability in the family | | |  | | | | | |
| Do any of the children have a caring responsibility | | | | | |  | |  |
| Please list all children with caring responsibilities | | | | | |  | | |
| Has community-based support been explored | | | | | |  | |  |
| Please list community support explored | | | | | |  | | |
| Has a graded Care Profile been completed | | | | | |  | |  |
| If ‘Yes’, please send a copy with this referral | | | | | | | | |
| Have any Family Support/ Teams round the child meetings been held and if so, what was the outcome | | | | | |  | | |

**Assessment Information**

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| **What are you worried about?**  What is the history/sequence of events that has led up to your request? What further document(s) or agency chronology could you submit? Is there actual harm? What action is causing the harm? What is the factual information and evidence base specific to your concern?  What are the future risks for this child(ren)/family should this concern not be addressed? What are the complicating factors for this child(ren) and/or family that make the concerns more difficult to deal with? What are the views of the child(ren), young person or their family?  Please outline the concerns including details of impact at home and in school? Please attach any relevant reports or plans. |
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| **What is going well for this family and what resources/services are already in place?**  What is going well? Who is providing support to the family, (family, friends, professionals) and what does this support looks like? What are the views of the child(ren), young person and/or their family? |
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| **What needs to change to make things better/safer for this child(ren)?**  How can professionals working with the family, extended family members and their wider community support change? What does the family think would support them to reduce these concerns and what are they most worried about? What do you think would help to reduce the concerns and risks to this child(ren), young person, family? |
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**Information Sharing and Consent**

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| Information collected as part of this referral is so that we can understand the level of help and support you may need.  To ensure that you and your family are provided with the most effective support, it may be necessary to share/collect personal information about you and your family with our partner agencies / community groups, such as Children’s Services, other NHS services and health providers (including GPs), Education Services and Schools.  In some circumstances, information can be shared between agencies without consent, for example where sharing information might help to prevent a crime or safeguard the welfare of a child or young person. |

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| **I AGREE TO TEXT ALERTS BEING SENT TO MY MOBILE PHONE TO REMIND ME OF AN APPOINTMENT** |  |  |

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| **As the assessor I can confirm that the family have read and consented to the information in this referral and have also consented to this information being shared with the above agencies. Parents/Carers will be informed of the contents of this referral during the assessment process.** | | |
| Assessor name: | Signed (Assessor) | |
|  |  | |
| Parent/carer/child/young person name: | Signed (Parent/carer or child/young person) | |
|  |  | |
| Date signed (by Parent/carer or child/young person) | | Enter a date. |

NOTE! If there is evidence or reasonable cause to believe a child/young person is suffering, or at risk of suffering significant harm, practitioners have a legal responsibility to inform Children’s Social Care.

Completed referral forms for Paediatric SLT should be emailed to: [slt.educationenquiries@nhs.net](mailto:slt.educationenquiries@nhs.net)

Or sent by post to: Hadleigh Clinic, 49 London Road, Hadleigh, Essex, SS7 2QL