Northern Lincolnshire and Goole NHS
NHS Foundation Trust

Speech & Language Therapy Service
Community School Referral

Print Code: WQN 629 Version: 2.1

1. Child's Details	
Child's Name:	☐ Male ☐ Female
NHS No:	DOB:
Full name of Parent / Guardian / Carer*: (*Please specify)	
Address:	
	Postcode:
Tel No:	Mobile No:

2. School Details	
School:	
Address:	
	Postcode:
Tel No:	Year Group:
Class Teacher:	SENCO:
Referral Date:	

3. Nature of Difficulty (Tick all relevant boxes and give examples of each)	
A) Understanding of Language: ☐ (Provide details)	
B) Speech Sounds: ☐ (Provide details)	
C) Sentences and Grammar: ☐ (Provide details)	
D) Vocabulary ☐ (Provide details)	
E) Stammering (if so):	
- Has the child stammer for more than 12 months? ☐	
- Does anyone else in the family stammer? ☐	

- Has anyone in the family stammered in the past? ☐

Name:	DOB:	NHS No:

3. Nature of Difficulty Continued
F) Other: (Please specify)
G) How does the difficulty affect the child in class? (Please give examples)

4. Associated Difficulties
Attention / Listening: ☐ (Comments or Stage)
Play: ☐ (Comments or Stage)
Social Interaction: ☐ (Comments or Stage)

5. Support Available
What support is available within school? (e.g. CSA time, SENSS)
What strategies / programmes have already been implemented? (e.g. Early literacy scheme)
Which sections of the ‘classroom strategies’ booklet (provided to all SENCO’s via the Speech & Language Therapy Department) have been referred to?

Name:	DOB:	NHS No:

5. Support Available Continued
What training have school staff received regarding speech and language difficulties?

6. Medical Details	
GP Full Name:	
Address:	
	Postcode:
Hearing Status:	Date of Test:
Has the child had any previous contact with the Speech & Language Therapy Service? (Please Comment)	
Other relevant information e.g. Visual Impairment, Physical Disability:	

7. Referrer's Details		
Name:		
Position:		
- Has the carer agreed to the referral being made?:	☐ Yes	☐ No
- Does the carer know their child will be discharged if they fail to attend their initial appointment without notification?:	☐ Yes	☐ No
Which clinic would they prefer to attend?	☐ Immingham	☐ DPOW Hospital
(Please note – We will endeavour to see this child at the clinic specified above, staffing levels may result in the 1st choice not being available)		
Signature of Referrer:	Date:	
Signature of Carer:	Date:	
(We are unable to accept the referral without <u>both</u> signatures)		

Name:	DOB:	NHS No:

Return to:

Appointments Clerk
Speech & Language Therapy Department
Diana Princess of Wales Hospital
Scartho Road
Grimsby
DN33 2BA