NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Speech & Language Therapy Service
Paediatricians / GP's Community Referral

Print Code: WQN 627 Version: 2.2

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:
School or Pre-School: *(Please specify name of school)*	

Primary Difficulty
☐ Speech / Language
☐ Multiple Difficulties

2. If Multiple Difficulties:
A) What type of difficulties do they have?
• ☐ Physical difficulties (moderate to severe) e.g. Cerebral Palsy
• ☐ Feeding difficulties
• ☐ Down syndrome
• ☐ Other syndrome *(Please specify)*
• ☐ ASD
B) ☐ Have you referred to CDC Multi-Assessment / completed a Single assessment?

3. Nature of Speech & Language Difficulties: *(Tick relevant boxes)*
A) ☐ Understanding of language
B) ☐ Speech sounds
C) ☐ Sentences

Name:	DOB:	NHS No:

3. Nature of Speech & Language Difficulties Continued

D) ☐ Vocabulary

E) ☐ Stammering

F) ☐ Other

4. Medical Details

GP Full Name:

Address:

Postcode:

Hearing Status:	Date of Test:

Has the child had any previous contact with the Speech & Language Therapy Services? *(Please specify)*

Involvement with any other Professionals: *(Please list below)*

5. Referrer's Details

Name:

Position:	Date:

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

N.B. FORMS WILL BE ACCEPTED WITHOUT A PARENTAL SIGNATURE

Return to:

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