NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Speech & Language Therapy Service
Community School Referral

Print Code: WQN 629 Version: 2.4

1. Child's Details	
Child's Name:	☐ Male ☐ Female
NHS No:	DOB:
Ethnicity	Religion
Full Names of Parent / Guardian / Carer*: *Please specify Please indicate person/s with parental responsibility	
Address:	
Postcode:	Date of Entry into UK: *(Referral to Overseas Dept if less than 12 months)*
Location of Patient:	
Please provide contact numbers as initial appointments may be arranged by phone	
Tel No:	Mobile No:
Languages spoken:	Is an interpreter required?
Is there an early help / CIN / or Child Protection plan in place?	
Is the child looked after? Social worker name:	

2. School details	
School:	Key Stage: FS / KS1 / KS2 / KS3
Address:	
Postcode:	Tel No:
Class Teacher:	SENCo:

Name:	Location of Pt:	NHS No:

3. Please describe the child's speech, language & communication needs

Child's understanding of spoken language:
Child's language use/expression:
Using sounds:
Social interaction:
Stammer:
Other:

3. REFERRAL INFORMATION

What measures relating to communication have been implemented prior to referral?
□ - Speech and language toolkit
□ - Language link, wellcomm or other published resource
□ - Support from other services
□ - other: _____

Please state specific measures / strategies / activities used:

b) What was the impact on the child/family?

c) Why do you feel the above measures are not sufficient/what concerns persist?

Speech and language therapist name: Date discussed with SLT :

4. Other relevant information

Does the child have difficulty with other skills / areas of development e.g. learning, cognition, medical, emotional, behaviour? Does the child show awareness of their difficulties?

Is the child known to any other agencies? e.g. paediatrician, educational psychology, CAMHS

5. Support Available in school

Name:	Location of Pt:	NHS No:

6. Medical Details

GP Full Name:
Address:

7. Referrer's Details

Referrer's Name:	
Profession:	
Contact Address	
Postcode:	Tel No:

8. Consent for referral

Referral to Speech and Language Therapy must be discussed with the parent / carer, and verbal consent gained. Please ensure the following is completed	
Does the carer know their child may be discharged if they fail to attend their initial appointment without notification? ☐ Yes ☐ No	
Signature of Referrer:	Date:
Signature of Carer:	Date:
Verbal consent gained from carer (where above signature is not provided	☐ Yes ☐ No

Please return the referral as soon as it is completed
By email: nlg-tr.NLChildrensTherapyTeam@nhs.net

By post: Speech & Language Therapy, Children's therapy team, Monarch House, Queensway Industrial Estate, Scunthorpe, DN16 1AL

Tel: 01724 203755

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