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NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

SPEECH & LANGUAGE THERAPY SERVICE REFERRAL FORM

Print Code: WQN-1496 Version: 1.7

☐ **Local Authority 2-3 Year old referrals** – requires EYs data sheet (0-19 HV referrals)

☐ **NHS Service:** Referrals are accepted from 3 years of age, currently children transfer to the school-based service in their reception year.

Referrals will only be accepted if this form is accompanied by:

- Completed pre-referral universal/targeted intervention table showing at least one cycle of Assess, Plan, Do, Review (APDR) with a minimum of 4-6 contacts for specific support and review at least one month after input sessions.
- For school age referrals this may include evidence from implementation of the Speech and Language Toolkit as well any other targeted interventions e.g. language link, welcomm over a school term.
- Please see guidance below for speech and dysfluency referrals.

Please summarise outcomes of your APDR cycles on the enclosed form. Individual record sheets of interventions will not be reviewed.

For further support in making referrals please contact the department on 01724 203 755 or see our website https://www.nlg.nhs.uk/services/speech-language-children/nlincs/

Dysphagia referrals: please complete the *Paediatric Speech and Language Therapy Community Referral: Eating and Drinking* form

1. CHILD'S DETAILS

Child's Name:	☐ Male ☐ Female
NHS No:	DOB:
Religion:	Ethnicity:
Full Names of Parent / Guardian / Carer*:	
Please specify person/s with parental* responsibility: *For children in our care CIOC (Looked after children) please include the social workers name and that they are aware of the referral*	
Address:	
Postcode:	
Home Tel:	Mobile:
Email address:	

Name:	NHS No:
DOB:	Location:

Is there an Early Help / CIN / or Child Protection plan in place? Name of social worker:	
Is the child in our care (looked after)? Is the social worker aware of the referral? Name of Social Worker: Contact details:	
Languages spoken:	Interpreter Required: ☐ Yes ☐ No Language required:
Is the child new to the UK? Date of Entry into UK: *(Referral to Overseas Dept if less than 12 months)*	If child has English as an additional language (EAL) please note how long they have been exposed to English for. For school age referrals, please refer to the information in the toolkit. Concerns in both home language and English are required for referral.

2. SETTING

Early Years provision / school attending:	
Which days / hours are they in setting?	
Key Stage: FS/KS1/KS2/KS3	
Address:	
Postcode:	Tel No:
Keyworker/Class teacher:	SENCo:
Email address:	

3. MEDICAL INFORMATION

GP Full Name:	
Address:	
	Postcode:
Hearing Status:	Date of Test:
Relevant Medical History:	

Name:	NHS No:
DOB:	Location:

Has the child had any previous contact with the Speech and Language Therapy Service?

☐ No ☐ Yes Please give details:

Dummy used until the age of:

4. REFERRAL INFORMATION

Please describe the child's speech, language & communication needs including setting and Parental concerns and functional impact on the child.
Please complete all sections and tick main areas of concern.

☐ Child's understanding of spoken language:

☐ Child's use of spoken language/expression:

☐ Speech sounds/pronunciation: *(For school age children where speech is the main area of concern, please include a completed speech screen from the toolkit. Please also see toolkit for information on red flags to refer immediately).*

☐ Social interaction:

☐ Stammer: *If this is your main concern, you do not need to do the APDR cycle but please answer the following questions:*
How long has your child been stammering for?
Who is concerned?
How does the stammer affect your child?
What advice / what have you tried so far?

☐ Other:

5. OTHER RELEVANT INFORMATION

Please provide information about the child's other skills / areas of development or diagnoses e.g. learning, cognition, medical, emotional, behaviour and social skills?

Name:	NHS No:
DOB:	Location:

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

6. WHAT SUPPORT IS AVAILABLE IN SETTING FOR ACTIVITIES / ADVICE?

We require attendance of school staff at appointments offered in school so that information can be shared and therapy advice provided.

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 can be gained, please state date discussed and agreed with parent		

8. RETURN TO:

Health visitor and Systm1 users should refer using electronic referral processes

Please save a copy of these forms for your own records and send originals to:-
Speech & Language Therapy Service
New Beacon House
Ridge Way
Scunthorpe
DN17 1AJ
Tel: 01724 203755
nlg-tr.NLChildrensTherapyTeam@nhs.net

Name:	NHS No:
DOB:	Location:

Your feedback matters to us…*To ensure we deliver a safe and quality service and to help us understand the experience you have of the care you receive from our staff we would value your thoughts about the service you received. You may be contacted as part of our quality assurance programme which is where we visit our teams and staff and talk to them about the care they provide to our patients or at any time during or after you have needed our services.*

To collect this feedback, we would contact you using the registered telephone number we hold in your care record. This feedback will be strictly anonymous and whilst we will share the feedback as part of the process, we will not share any details which may identify you.
We will never ask you any personal questions about your health during these telephone calls.
If you do not wish to speak to us, please say this when we call, we do not want you to feel pressured.

WQN-1496 Review date March 2029

Name:	NHS No:
DOB:	Location:

SUMMARY OF APDR CYCLE/S OF TARGETED INTERVENTION COMPLETED PRIOR TO REFERRAL

Please see our website for ideas on targeted interventions to try prior to referral
https://www.nlg.nhs.uk/services/speech-language-children/resources-for-parents/

If you are unsure about strategies and interventions to try, or whether APDR is required, please contact us.

Short term outcome **ASSESS / PLAN**	Intervention **DO**	Dates of sessions **(minimum of 4-6 weeks)** **DO**	Date of review **(at least one month after sessions)** The referral will be rejected if no review information is provided. **REVIEW**
e.g. "To achieve two key word level understanding"	*S&L Toolkit, ASQ/ELIM resources, setting specific tools, Language Link, Wellcomm*	*5.3.24 12.3.24 19.3.24 26.3.24*	*6.5.24 Progress made with attention and listening however continues to have difficulty following instructions with 2+ key words, speech sounds remain unclear*

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DOB:	Location:

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