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| **Speech & Language Therapy Service****Community School Referral**Print Code: WQN 1629 Version: 2.5 |
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| **1. Child’s Details** |
| Child’s Name: | [ ]  Male [ ]  Female |
| NHS No: | DOB: |
| Full name of Parent / Guardian / Carer\*: (\*Please specify) |
| Address: |
| Home Language:Interpreter needed: [ ]  Yes / [ ]  No | Postcode: |
| Tel No: | Mobile No: |
| Date of Entry into UK: *(Referral to Overseas Dept if less than 12 months)* |
| **2. School Details** |
| School: | Key Stage: KS1 / \*KS2 / \*KS3 |
| Address:Postcode: | \*For KS2 + report from Learning and Cognition Team / or Educational Psychologist will be required before the referral will be accepted (excluding Stammering)[ ]  Report attached[ ]  Not required / Stammering |
| Tel No: |
| Class Teacher: | Year Group: |
| Referral Date: | SENCo: |
| **3. Please Describe the Child’s Speech and Language / Communication Difficulties and the impact of this** |
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| Name: | NHS No: |
| Location: | DOB: |

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| Stammering (if so): |
| [ ]  Has the child stammered for more than 12 months? |
| [ ]  Does anyone else in the family stammer?  |
| [ ]  Has anyone in the family stammered in the past? |

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| **4. Associated Difficulties** |
| [ ]  Attention / Listening: (Comments or Stage) |
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| [ ]  Play: (Comments or Stage) |
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| [ ]  Social Interaction: (Comments or Stage) |
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| **5. Please detail what support and strategies you have already provided and the outcome of this. NB referrals will not be accepted without evidence of targeted support already trialled prior to referral.** |
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| **6. Medical Details**  |
| GP Full Name: |
| Address: |
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|  | Postcode: |
| Hearing Status: | Date of Test: |

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| --- | --- |
| Name: | NHS No: |
| Location: | DOB: |

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| Has the child had any previous contact with the Speech and Language Therapy Service? (Please comment)  |
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| Other relevant information e.g. Visual Impairment, Physical Disability, Bilingual / EAL |
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| **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 both signatures) |

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| Return to:Appointments ClerkSpeech & Language Therapy DepartmentDiana Princess of Wales HospitalScartho RoadGrimsbyDN33 2BA |

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