

**Speech and Language Therapy Department  
Children and Young People's Services Referral Form**



Child's Name..... CHI No.....

Date of Birth.....Parent/Guardian's Name.....

Address .....

.....Postcode.....

Tel. Nos. Home..... Other.....

Nursery/School.....

GP.....Address.....

PHN (HV).....Address.....

Other professionals involved (please tick all that apply):

Occupational Therapist  Physiotherapist  Learning Support

Classroom Support  Social Services  Child & Family Services

Educational Psychologist  Reach Out

Others (please specify).....

Does the child have a Coordinated Support Plan? Yes  No  Don't Know

Does the child have an Individual Educational Plan? Yes  No  Don't Know

Has the child been referred to /seen by an SLT previously? Yes  No

If yes, state when? .....

What was the outcome? .....

Has the child's hearing been assessed excluding birth check? Yes  No

If yes, when? .....

What were the results? .....

Does the child have difficulty in any of the following areas? (Please tick all that apply)

- |                                     |                          |                         |                          |
|-------------------------------------|--------------------------|-------------------------|--------------------------|
| Eating and drinking                 | <input type="checkbox"/> | Stutter/Stammer         | <input type="checkbox"/> |
| Understanding of spoken language    | <input type="checkbox"/> | Social interaction      | <input type="checkbox"/> |
| Expressive language/use of language | <input type="checkbox"/> | Attention and listening | <input type="checkbox"/> |
| Speech sounds                       | <input type="checkbox"/> | Play/Behaviour          | <input type="checkbox"/> |
| Persistent voice problems           | <input type="checkbox"/> |                         |                          |

Please give details .....

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Are there any child welfare / child protection concerns? Yes  No

If yes, please give details.....

Are there any reasons why this child/family would find it difficult to attend their local community clinic? Yes  No

If yes, please give details.....

Any other associated difficulties e.g. visual, physical difficulties, socio-emotional difficulties?

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Name of referrer (please print) .....

Address.....

.....Postcode.....

Designation.....Tel No.....

Does the parent/guardian agree to this referral and has the reason for referral been explained?

Yes  No

Is the child/young person in agreement with this referral and has the reason for referral been explained?

Yes  No

Signed.....Date.....

**Please send this Referral Form to your Local Speech & Language Therapy Department**