|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **REQUEST FOR SUPPORT FROM SPEECH AND LANGUAGE**  **THERAPY**  **INC MAINSTREAM NURSERY CHILDREN**  **Note for ALL Schools:**   * **This form is to be completed prior to discussion with School’s link SLT** * **Please email an electronic version of this form to:** [**SALT.Referrals@srft.nhs.uk**](mailto:SALT.Referrals@srft.nhs.uk) * **Families will then be contacted directly regarding an appointment for assessment.**   **School:**  **Link SLT:**  **Date RfS Discussed with Link SLT:** | | | | | |  |
|  | | | | | | |
| **Child’s First Name (s):** | | | | **List other Professionals involved**  **(provide name if known)** | | |
| **Surname:** | | | |
| **NHS Number:** | | | | ☐ | **Audiology** |  |
| **DOB** | | **Sex:** | M / F | ☐ | **Educational Psychology** |  |
| **Address:** | | | | ☐ | **Paediatrician** |  |
| ☐ | **ENT** |  |
| ☐ | **Family support Worker** |  |
| **Postcode:** | | | | ☐ | **School Nurse** |  |
| **Tel No:** | | | | ☐ | **Occupational Therapist** |  |
| **Alternative No’s:** | | | | ☐ | **Physiotherapist** |  |
| ☐ | **Other** |  |
| **GP:** | | | | ***Please include relevant reports / assessments*** | | |
| **Family Assessment Completed** | | YES / NO/ NA |
| **Language spoken at Home:** | | | | **LAC** | | YES / NO |
| **Interpreter Needed:** | YES / NO | | | **Known to Social services** | | YES / NO |
|  | | | | **Previous referral to SLT:** | | YES / NO/ Not Known |
| **Year group:** | | | |  | |  |
| **Has the child received input from Enhanced / Independent Speech and Language Therapist? (Please name if known)** | | | | | | |
|  | | | | | | |

|  |  |
| --- | --- |
| **Copy of Appointment letter to be sent to SENCO** | ☐ |

|  |  |
| --- | --- |
| **SENCOs Details** | |
| **Name:** | **Contact Tel No:** |
| **Contact Address:** | **Email Address:** |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Hearing Test Results**  *(if applicable, with Date)***:** | |  | |
| **Educational Psychology Assessment:** | | | **YES** *(please Attach Report)* **/ NO / REFERRED** |
| **SEND Level:** | **PRE- SEND / SEND / EHCP** | | |

|  |
| --- |
| **English As An Additional Language (EAL)** |
| **How long has the child been exposed to English?** |
| **Do parents / carers feel that there is a problem in the child’s home language?** |
| ***(We do not accept referrals for children who have been exposed to a rich English speaking environment for less than 12 months, unless there is a recognised difficulty in the child’s first language).*** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please refer to the age-related norms at** [**www.talkingpoint.org.uk**](http://www.talkingpoint.org.uk) **and describe the child’s difficulties in each area, providing as much detail as possible and including relevant examples. State NONE if not a concern** | | | | | | | | | | | | |
| **COMPREHENSION** | | | | | | **EXPRESSIVE LANGUAGE** | | | | | | |
| *Difficulties understanding what is said and following instructions* | ***Yes*** | **☐** | | ***No*** | **☐** | *Difficulties expressing him / herself using appropriate vocabulary and sentences* | ***Yes*** | | **☐** | ***No*** | **☐** |
| ***If yes, please describe*** | | | | | | ***If yes, please describe*** | | | | | | |
| **SPEECH CLARITY** | | | | | | **SOCIAL INTERACTION** | | | | | | |
| *Difficulties using clear speech appropriate to age* | ***Yes*** | **☐** | | ***No*** | **☐** | *Difficulties interacting appropriately with peers and adults verbally and non-verbally* | ***Yes*** | **☐** | | ***No*** | **☐** |
| ***If Yes please complete***   |  |  |  |  | | --- | --- | --- | --- | | **Cat** |  | **Man** |  | | **Fish** |  | **Table** |  | | **Lion** |  | **Sauce** |  | | **Blue** |  | **Green** |  | | **Spider** |  | **Chips** |  | | | | | | | ***If yes, please describe*** | | | | | | |
| **FLUENCY SPEECH / STAMMERING** | | | | | | **VOICE** | | | | | | |
| *Difficulty with speaking fluently without excessive pausing, repetition or stretching out sounds* | ***Yes*** | | **☐** | ***No*** | **☐** | *Unusually hoarse / croaky voice / loud / quiet voice* | ***Yes*** | | **☐** | ***No*** | **☐** |
|  | | | | | |  | | | | | | |
| **OTHER** | | | | | | **IN SUMMARY GENERAL DEVELOPMENT covering all areas** | | | | | | |
| *e.g. Child’s Play Skills, behaviour, self-help, attention and listening skills* | | | | | | |  |  | | --- | --- | | Below Average | **☐** | | Average | **☐** | | Above Average | **☐** | | | | | | | |
|  | | | | | |
| **DOES THIS CHILD’S ABILITY TO COMMUNICATE DIFFER FROM HIS / HER ABILITIES IN OTHER AREAS?** | | | | | | | | | | | | |
| *(if over 7 years of age, please include evidence of a child’s non-verbal abilities or abilities within other academic areas)* | | | | | | | | | | | | |
|  | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Discussion between Referrer and Patient / Carer** | | | | | | | | |
|  | ***NONE*** |  |  |  | ***SIGNIFICANT*** | |  |
| Level of Parental Concern | **0** | **1** | **2** | **3** | **4** | **5** |  |
| Level of Referrer Concern | **0** | **1** | **2** | **3** | **4** | **5** |  |

|  |  |  |
| --- | --- | --- |
| **What specific strategies have you used to develop the child’s speech / language / communication skills? Please also include a copy of the child’s latest Play Plan / Intervention targets.**  *(NB. Under new guidelines, where language concerns have been outlined on the referral but intervention targets are purely around literacy and numeracy your referral may be returned.* | | |
| **1:1** | **Group** | **Whole Class** |
|  |  |  |

|  |  |
| --- | --- |
| **What do you hope to gain from this referral?** | |
| **School:** |  |
| **Parents:** |  |
| **Child / Young Person**:  *(if appropriate)* |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **In summary, what are your main concerns for this child? Please tick** | | | |
| Speech / Language / Communication | **☐** | Cognitive skills | **☐** |
| General Development | **☐** | Literacy | **☐** |
| Social / Emotional | **☐** | Behaviour | **☐** |
| Self Help Strategies | **☐** |  | **☐** |

**SENCO’s Signature: Print:**

**Link SLT’s Signature: Print:**

Date:

***PLEASE EMAIL COMPLETED FORM TO:*** [**SALT.Referrals@srft.nhs.uk**](mailto:SALT.Referrals@srft.nhs.uk)

|  |
| --- |
| **WHICH APPOINTMENT NEEDED:**    INITIAL ASSESSMENT SALT ENHANCED TEAM LAC (Reception+ age pass to FT) |

**Interpreter Needed?**

**Yes: No:**

**Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**