**SECONDARY SCHOOLS REFERRAL FORM**

**SPEECH AND LANGUAGE THERAPY**

*Please note that this form will be returned if essential information is not provided.* *Areas marked with \* are mandatory in order for form to be processed. Thank you*

|  |  |
| --- | --- |
| ***Name\*:*** | ***NHS Number\*:*** |
| ***Male/Female (please circle)***  | ***DoB\*:*** | ***Age:*** |
| ***Address\*:******Postcode:*** | ***Ethnic Origin\*:*** |
| ***Tel No\*:*** |
| ***Other Tel No:*** |
| ***Language/s spoken at home\*:*** | ***Interpreter needed\*:***  Y / N (please circle) |
| ***Has the child’s hearing been tested in the last 12 months? \* Yes/ No*** *(If Yes, please circle and provide date)* ***Date:*** | ***Outcome of Hearing Test:*** |
| ***GP\*:*** | ***GP Address\*:*** |
| ***School Nurse\*:*** | ***School Nurse Address:*** |
| ***School \*:*** | ***SENCo\*:*** |
| ***School Educational Psychologist:***  | ***School Year\*:*** |
| ***Other Professionals Involved\*:***(e.g. Social services, OT, CDT: please list with contact details and attach most up to date report/s if available) | ***Teaching Assistant\*:*** *(linked to student or class)* |

***Reason for referral \**** (tick area of concern and provide comment/s)

|  |  |  |
| --- | --- | --- |
| ***Difficulty*** | ***🗸***  | ***Observations/reasons for concern in this area*** |
| **Feeding** |  |  |
| **Speech Sounds** (pronunciation) |  |  |
| **Voice\*** (e.g. husky voice, poor intonation) |  | **\*Has the child been seen by ENT?** If yes please attach report |
| **Fluency/Stammering**(e.g. repeating sounds/words, stopping completely) |  |  |
| **Only Speaking in certain situations / Shy & Anxious** |  |  |
| **Hearing Impairment** (e.g. in the class group/one-to-one - able to sit still, distractible) |  |  |
| **Social Skills**(e.g. eye contact, taking turns, understanding social situations, interaction with peers) |  |  |
| **Language** (Attention & Listening, Understanding, Expression) |  |  |
| **Other** |  |  |

***What Curriculum levels is the student currently functioning at?\****

***Has the child received speech and language therapy before?*** Yes / No

*If YES: what is the reason for re-referral?*

There has been limited progress since the last SaLT consultation □

There has been a change of circumstance or environment for the child □

New difficulties have come to light □

The child has moved into Ealing □

Other……………………………………………………………………………… □

***What training has been accessed by school staff to support the identified communication needs?***

***What support has been put in place to manage these difficulties at home/in school?***

**Please note that if the student being referred has not accessed relevant targeted provision related to the concerns the referral may be returned.**

|  |  |  |
| --- | --- | --- |
| ***Difficulty*** | ***Group Support provided/***  | ***Other*** |
| **Hearing Impairment** | **Vocab group 🞏** **Narrative Group 🞏** |  |
| **Social Skills** | **Social Skills Group 🞏****Lego Therapy 🞏** |  |
| **Language** | **Vocab group 🞏****Narrative Group 🞏****Higher Level Language Group 🞏** |  |
| **Other** |  |  |
| **Relevant observations from Groups/ support provided – please attach outcomes from the interventions to the referral form\*** |

***Information about non-verbal skills (tick if a concern)***

|  |  |  |
| --- | --- | --- |
| ***Difficulty*** | ***🗸 / 🗴*** | ***Observations/reasons for concern in this area*** |
| ***Behaviour*** (e.g. motivation, confidence) |  |  |
| ***Learning*** (e.g. memory, generalising information) |  |  |
| ***Physical*** (e.g. gross & fine motor skills) |  |  |

***Other relevant information / Students’ perception of their difficulties***

***Documents to be attached: (tick appropriate box)***

\*Reports/information from other professionals 🗆 (where possible please include Educational Psychology report)

\*Outcomes from targeted groups the student has attended in school 🗆

## Information for Parents/Carers and Schools

(if referrer is any other professional please explain this fully to parent/carer)

By making this referral you are committing to working with and providing the necessary support to carrying out the advice given and recommended by the Speech and Language Therapist. Should the advice/recommendations not be carried out the child will be discharged from the service.

***Referrer Name\*:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Referrer Role\****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Referrer Signature\*:***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Date:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Address and Tel. No. of Referrer\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***SLT Name\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SLT Signature\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Parent/Carer Consent \****

I fully understand the reasons for this referral and agree to the referral

 I agree to assessment information and recommendations about the child’s speech, language

 and communication being shared between the Service, Education Staff and Health

 Professionals

***Parent/Carer Name\*:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Parent/Carer Signature\*:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please return to: Speech and Language Therapy, Carmelita House, 21-22 The Mall, Ealing, W5 2PJ, Fax: 020 8825 8755

***If you have any questions please call our SLT Administrator on 020 8825 8856***