Office Use Only

NHS
Coventry and Warwickshire Partnership
NHS Trust

For SLT Commissioning Schools / Nurseries Only Initial assessment to be at: **CoCHC / In School**
(Please delete as appropriate)

CHILDREN'S SPEECH & LANGUAGE THERAPY REFERRAL FORM

(Communication only)

CHILD'S NAME: ..... DOB: ……NHS No: ……

NAME OF REFERRER: ..... DESIGNATION:……..

REFERRAL DATE:..... REFERRER PHONE NO:……

REFERRER ADDRESS: ……..

For swallowing and feeding concerns please use our Speech and Language Swallowing and Feeding (Dysphagia) referral form

A referral will be accepted for children under 18 months of age for:

- ❒ Moderate - Severe bilateral sensori - neural hearing loss (up to the age of 3 years)
- ❒ Cleft palate (up to the age of 3 years)
- ❒ Acquired brain injury (occurred in the last 12 months)

A referral will be accepted for children over 18 months of age for:

- ❒ Pre 30 week gestation (up to the age of 3 years.)
- ❒ Looked After Child with communication difficulties
- ❒ Medical condition / syndrome with known related severe speech and language difficulties
- ❒ Referred by Consultant Paediatrician
- ❒ Voice difficulties (must have been assessed by Ear, Nose & Throat Consultant)
- ❒ Child/Young Person attends a setting that commission a Speech and Language Therapy service from CWPT (please ask parent/ carer to sign the consent section below)

- ❒ **A referral will be accepted for children who have concerns around speech sound development or stammering from 2 ½ years old**

All other children referred must be over 2 years old and have received a period of intervention for a minimum of 3 months (e.g. additional support from health visitor / teaching assistant)

Has the child been given a period of intervention for a minimum of 3 months?

Yes ☐ **No** ☐

Please answer the following questions: -

Please provide a period of intervention for 3 months and refer if concerns remain

What type of intervention has been provided?……

……

What progress has been made?……

How long has the intervention been provided for?……

If the child does not meet the criteria above a referral cannot be accepted

Mel Coombes - Chief Executive

PLEASE ENSURE THAT THIS FORM IS FILLED IN FULLY. IT WILL BE RETURNED TO YOU IF ITEMS ARE NOT COMPLETED. PLEASE CROSS OUT ANYTHING THAT IS NOT APPLICABLE

HEALTH PROFESSIONALS ARE ONLY REQUIRED TO FILL OUT NAME, DOB, NHS NUMBER & EDUCATION SETTING

CHILD'S DETAILS Sex: M F	PARENT / CARER 1:	PARENT / CARER 2:
Date of Birth:	First Name:	First Name: .....
NHS Number (if known):	Surname:	Surname: .....
First Name(s):	Relationship to child:	Relationship to child: .....
Surname:	Address (if different from child)	Address (if different from child)
Address:	.....	.....
.....	.....	.....
Postcode:	Postcode:	Postcode: .....
Telephone:	Telephone:	Telephone: .....
Email address:	Holds parental responsibility? Yes / No	Holds parental responsibility? Yes / No
	If no, please provide details of who does hold responsibility:	If no, please provide details of who does hold responsibility: .....

GP:	Nursery / School: .....
Address:	Teacher's Name: .....

Language(s) spoken by child (Incl. dialect if relevant): .....

Language(s) spoken by parent/carer (incl. dialect if relevant): .....

Interpreter needed for parent Y N or child? Y N

Length of time the child has been exposed to English?.....

Are there concerns about the child's understanding and use of their home language? If yes, please give details;

.....

Religion:.....

Ethnic Origin (Please tick)

	English, Welsh, Scottish, Northern Irish or British		White & Asian		Any other Asian background
	Irish		Any other Mixed or Multiple ethnic background		African
	Gypsy or Irish Traveller		Indian		Caribbean
	Any other White background		Pakistani		Any other Black, African or Caribbean background
	White & Black Caribbean		Bangladeshi		Arab
	White & Black African		Chinese		Any other ethnic group

Known / referred to other Professionals:

(please tick)

- ○ Audiology
- ○ Complex Communication Team
- ○ SEMHL
- ○ Occupational Therapy
- ○ CAMHS
- ○ Educational Psychology
- ○ Physiotherapy
- ○ Medical Consultant / Paediatrician
- ○ SEND Early Years
- ○ Early Support
- ○ Neurodevelopmental Team
- ○ Other (please specify)

Known to Social Care? Y N

Named Social Worker and Base: .....

.....

Does the child have a EHCP? Y N

Does the family have a CAF? Y N CAF Level .....

CAF Lead and Base: .....

.....

Mel Coombes - Chief Executive

MINDFUL EMPLOYER

Coventry and Warwickshire Partnership NHS Trust
Wayside House, Wilsons Lane, Coventry, CV6 6NY
Tel: 024 76961 455

disability confident EMPLOYER

Relevant child & family, developmental and medical history (e.g. learning, hearing, visual, mobility, mental health, medical diagnosis, behavioural difficulties):

.....
.....
.....

PLEASE TELL US ABOUT THE CHILD'S DIFFICULTIES & GIVE EXAMPLES:

1) Understanding e.g. following instructions		6) Voice e.g. hoarseness **NB. Needs ENT referral**	
2) Use of Language e.g. using words and sentences		7) Social communication e.g. eye contact, turn taking	
3) Speech e.g. saying words clearly		8) Other e.g. cleft palate, hearing impairment	
4) Stammer/Stutter		9) Behaviour	
5) Attention/Listening		For swallowing and feeding concerns please use our Speech and Language Swallowing and Feeding (Dysphagia) referral form	

What would you like to achieve from this referral?

.....
.....
.....

Has parent/carer/young person agreed to this referral Yes / No

Complete this section if commissioned provision only:

I agree:

- to an assessment by the Speech and Language Therapy Service as appropriate for my child **Yes / No**
- **for my child to be seen in school/nursery (face to face or virtually) even if I am unable to be present** **Yes / No**
- for my child to be seen by a SLT student under the supervision of a qualified SLT **Yes / No**
- for information to be shared with other professionals (inc. local authority) **Yes / No**
- for information to be communicated between any independent speech and language therapists (SLTs) who are involved with my child and the NHS SLT service **Yes / No**
- for my child to be photographed / videoed for clinical purposes **Yes / No**
- for an interpreter to be present at my child's appointment, if required **Yes / No**
- for staff at my child's nursery/school/other professionals to request further appointments for my child on my behalf **Yes / No**
- to be contacted via:
  - * email **Yes / No**
  - * text message **Yes / No**
  - * voice mail messages **Yes / No**

Signed: ..... (Parent/Guardian) Print Name:…….

Date: ……

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You can access our website for general information and waiting times at the following address
www.coventrychildrenssIt.co.uk

Please note: referrals will only be accepted if the child or young person is registered with a Coventry GP

Please return: via email to Referrals.ChildrensPhysicalHealth@covwarkpt.nhs.uk

Or post to:
Children's Speech and Language Therapy Service
Wayside House
Wilsons Lane
Coventry
CV6 6NY

Telephone: 024 76961455

Additional Information for school aged children only

EDUCATION PROFILE

How well is this pupil achieving compared to their peers. Please complete the tables below.

	Well below average	Below average	Average	Above average	Well above Average
Reading ability					
Writing ability					
Spelling ability					
Maths ability					

COMMUNICATION PROFILE

	Major problem – achieves less than 50% of the time	Medium problem – achieves 50% of the time	Minor problem – achieves 70% of the time	No problem – achieves 90% of the time
Attention a) Attention in class				
b) Attention in small group				
c) Attention in 1:1 situation				
Receptive language a) Following class instructions				
b) Following group instructions				
c) Following 1:1 instructions				
d) Understanding curriculum vocabulary				
e) Understanding everyday words				
f) Responding appropriately to questions				
g) Understanding a story				
h) Following class routines				
i) Following sequenced instructions				
Expressive language a) Using appropriate vocabulary				
b) Using appropriate sentences				
c) Ability to ask for help				
d) Ability to give explanations				
e) Ability to ask questions				
f) Ability to retell a simple story				
Speech (Clear pronunciation) a) Spoken single words				
b) Spoken sentences in context				
c) Spoken sentences when context not known				
d) Phonological Awareness / phonic skills				
Fluency a) Speed of spoken language				
b) Ease of talking				
c) Confidence to talk				
Voice (e.g. hoarse / high or low pitch a) Quality of voice production				
Social communication (pragmatics) a) Eye contact				
b) Behaviour in social situations				
c) Taking turns				
d) Conversation skills				
e) Playground behaviour				
f) Understanding abstract language e.g. idioms/jokes/sarcasms (8yrs + only)				
g) Understanding emotions of others				
h) Expressing own emotions				

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Additional Information

Please use this space to provide details of any other communication concerns or observations

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