Speech and Language Therapy

Referral for Assessment

School-age

The child you are referring

Name of Child			Date of birth
Surname(s) of parents			Next of Kin
Address			GP
Postcode			
Telephone numbers	Home	Work	Mobile
e-mail address:			
School		Year group	Teacher

You – the referrer

Referred by	Job title
Date of referral	Telephone number

Other professional agencies involved with this child? Tick box

Paediatrician	☐	Physiotherapist	☐
Psychologist	☐	Social services	☐
Occupational therapist	☐	Private therapist	☐
ENT/Audiology	☐	CAMHS	☐
School Nurse	☐	Dietician	☐

Languages spoken in the home

English	☐	Other(s)	
Is an interpreter required	☐		

Parental consent to referral

✓	I agree to this referral
✓	This referral has been explained to me and I understand the reason for this referral
✓	I understand that if I fail to attend my child may be discharged from the service
✓	I consent to sharing of relevant information e.g. written reports, with other professional staff involved with my child
Print full name	

Signature

NB: Second page must be completed.

Area of concern (tick appropriate box)

	Verbal comprehension and following directions **Note**: Please send the front page of the Language Link assessment screen with the score and the areas of need indicated.	☐
	General social and communicative interactions	☐
	Expressive language (vocabulary, sentence production, grammar)	☐
	Speech Pronouncing the following sounds: ..... **Note**: Please send the first sheet of the Speech Link with score and sounds in error indicated **Note**: It is not unusual for children under 8 years to have difficulty with 'r' and 'th' Therefore, referral for these sounds only would be inappropriate. Also, a referral for a lisp only before adult teeth have grown is inappropriate.	☐
	Stammering, dysfluency or intonation (melody of speech)	☐
	Voice quality: huskiness, loss of voice, pain when speaking	☐

Description of communication difficulty (please expand on above)

Further information

1	How does the child compare to his/her peers in skills unrelated to speech or language?				
2	Is the child on the special needs register	Yes	☐	No	☐
3	Does the child have a diagnosis of general or specific learning difficulty or developmental delay?	Yes	☐	No	☐
	If 'yes' please describe				
4	If a monitored programme is considered appropriate, would there be Provision to carry out the programme? (individual or small group work e.g. 3 x 30 minutes per week)	Yes	☐	No	☐

Please attach any recent reports (e.g. Educational Psychology) to this referral. You **must** seek parental permission for sharing this with our service.

Please return the completed referral form to:

Children's Therapy. Central Community Health Centre, Westmoreland Road, Douglas. IM1 4QA

Telephone: 01624 642563