**Ealing Children’s Speech and Language Therapy**

**Referral Form**

*Please note that areas marked with* ***\**** *are mandatory for this form to be processed. Thank you.*

**Please email this form to:** **ealingcommunity.referrals@nhs.net**

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| ***If you are referring the child for the Joint Assessment Clinic (JAC) please tick here:***[ ] *(JAC is a joint assessment clinic run by SLT and CDT after which an Autism assessment may be recommended - see Appendix 1 for more information).* |

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|  **Child’s Details**  |
| **Name\*:** |  | **GP\*:** |  |
| **NHS Number\*:** |  | **GP Address\*:** |  |
| **Date of birth\*:** |  | **Health Visitor/School Nurse\*:** |  |
| **Gender:** |  | **School/Nursery\*:** |  |
| **Ethnicity\*:** |  | **School/Nursery SENCo:** |  |
| **Home Address\*:** |  | **School/Nursery Year:** |  |
| **Telephone(s)\*:** |  | **Stage on Code of Practice:** | [ ] None [ ] SEN support [ ] EHCP |
| **Email(s)\*:** |  |
| **Other professionals involved\*:**(e.g. Social Care, OT, CDT, Hospital (including department and Consultant details): please include contact details and attach report/s if available) |  |

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| **Languages** |
| **Child’s main language(s)\*:** |  | **Parent/carer’s main language(s)\*:** |  |
| **Does the parent/carer need an interpreter\*:** | [ ] **No** [ ] **Yes - language required:** |

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| **Hearing Test** |
| **Date of last hearing test and result\*:** |  |
| **If hearing test result not available, please refer to Audiology - date referred\*:** |  |

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| **Family - who lives at home?** |
| **Name** | **Date of Birth** | **Position in the Family** | **Parental responsibility? (Y/N)** |
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| **Family History** (please note relationship to the child) |
| **Late talking:** | [ ] No [ ] Yes | **Deafness/hard of hearing:** | [ ] No [ ] Yes |
| **Speech/pronunciation difficulties:** | [ ] No [ ] Yes | **Learning difficulties:** | [ ] No [ ] Yes |
| **Stammering/stuttering:** | [ ] No [ ] Yes | **Neurodevelopmental conditions e.g. Autism or ADHD.** | [ ] No [ ] Yes |
| **Language difficulties/DLD:** | [ ] No [ ] Yes | **Specific Learning Difficulties** **e.g. Dyslexia** | [ ] No [ ] Yes |

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| **Development History** |
| **Difficulties with pregnancy:** |  | **Difficulties at birth:** |  |
| **Age of taking solid food:** |  | **Age of sitting:** |  |
| **Age of walking:** |  | **Age out of nappies:** | Day: | Night: |
| **Age of first sounds: (e.g. ‘baba’, ‘gaga’)** |  | **Age of first words/signs:** |  |
| **Does the child use a dummy?:** | [ ] No [ ] Yes | **Any medical diagnoses:** |  |

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| **Reason for Referral\*** |
| **Area of Difference or Difficulty** | **Observations/Reasons\*** |
| **Attention and Engagement**(e.g. do they respond to others, do they need help to do so, are they self-directed, following own choice of activities, is it hard to stop activities at an adult’s request, are they engaging in adult-led activities not chosen by them, what is their attention like in different settings e.g. one-to-one/group/class?) |  |
| **Understanding language**(e.g. following instructions, understanding questions, understanding vocabulary.)  |  |
| **Using Language & Communicating**(e.g. how the child interacts and communicates with others / their preferred methods of communication – e.g. sounds / signs / words / movements / gaze, using vocabulary, in sentences, expressing needs, discussion) |  |
| **Social communication, play and social understanding**(e.g. who they communicate with and why, their interest in or awareness of other children, their friendships, their play interests, how they navigate social or play situations with others, e.g. sharing toys or coping with others joining their play. How they understand social situations or work out what other people might feel or think.) | *If this child is under 6 years and requires further assessment of their differences (e.g. Autism Assessment), instead please complete Appendix 1: Joint Assessment Clinic Essential Information with parent/carers.*  |
| **Speech Sounds** (pronunciation of sounds) |  |
| **Voice**(e.g. husky voice, intonation) | *If the child has been seen by ENT please attach the report.* |
| **Stammering**(e.g. repeating sounds/words, stopping completely, avoiding word or speaking situations) | *If the child is aged 7 years + please complete Appendix 2: Stammering referral screener the with child & parent.* |
| **Eating, Drinking and Swallowing**(dysphagia e.g. coughing whilst eating/drinking and parent/carer level of concern) | *Please also complete appendix 3.* |

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| **Support Already Happening\****(please note referrals will be rejected unless support is currently in place).* |
| **What current support is in place to develop the child’s communication skills and what support has been given to parent/carers\*:**  |
| (e.g. phonological awareness, visual supports, Attention bucket/builder, intensive interaction strategies, lego therapy, Box Clever, emotional regulation support.) |
| **What support has the family accessed outside of a Nursery/School setting\*:** |
| [ ]  5 Talk and Play sessions | [ ]  5 Fun and Learn sessions |
| [ ]  Makaton Sign Time group | [ ]  ELIM |
| [ ]  Other Children’s Centre sessions (please note): |
| [ ]  Parent/carer workshop (please note): |
| [ ]  Other eg, Youtube videos, Facebook information (please note): |

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| **Referrer Details\*** | **Parent/Carer Details and Consent\*** |
| **Referrer name:** |  | **Parent/carer name:** |  |
| **Referrer signature:** |  | **Parent/carer signature:** |  |
| **Referrer role:** |  | [ ] I understand the reasons and agree to this referral. |
| **Referrer email:** |  | [ ] I agree to assessment information being shared between NHS staff, Education Staff and the person who referred me, if different. |
| **Referrer telephone:** |  | Does anyone in the family have any accessibility requirements for meetings? [ ] No [ ] Yes -  |
| **Date:** |  | *If you are referring to the Joint Assessment Clinic, please also ensure parent/carers complete the consent box in Appendix 1.* |
| **Date:** |  |
| **If referral is being made by school, please discuss it with the SLT and provide their signature\*:** |  |
| *By making this referral, parents/school staff are committing to carrying out the advice recommended by the service. Should the advice not be carried out, the intervention provided will be reviewed. (Please explain this to the parent/carer)* |

**APPENDIX 1: JOINT ASSESSMENT CLINIC (JAC) - ESSENTIAL INFORMATION**

*This clinic is provided by the Child Development Team and Speech and Language Therapy team for children aged 2 years 6 months – 5 years 11 months. It is for children with social communication differences who may be autistic.*

*If you are referring to this clinic, please discuss this with parents/carers to gain their consent (you will need to discuss that an Autism assessment may be a follow-up step after the clinic appointment.)*

*NB: Children need to have accessed regular support activities for at least 1 term. Please complete the ‘Support Already Happening’ box above.*

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| **Reason for Referral to Joint Assessment Clinic (JAC)\*** |
| **Area of Difference or Difficulty** | **Observations/Reasons** |
| **Social communication, play and social understanding**(e.g. how the child interacts and communicates with others / their preferred methods of communication – e.g. sounds / words / movements / gaze, who they communicate with and why, their interest in or awareness of other children, their friendships, their play interests, how they navigate social or play situations with others, e.g. sharing toys or coping with others joining their play. How they understand social situations or work out what other people might feel or think.) |  |
| **Emotions awareness and emotional regulation**(e.g. how they communicate their feelings, how they cope with/regulate their feelings, are there meltdowns or shutdowns and when do these happen.) |  |
| **Repetitiveness and flexibility**(e.g. do they enjoy repeating things e.g. sounds, words, phrases, songs, movements (stimming), activities or play. Do they return to a favourite topic or game/interest very frequently. How do they cope when something familiar changes or looks different.) |  |
| **Sensory differences** (e.g. sensitivity to or preference for textures, things they can touch, sounds, tastes, smells, light etc.)  |  |

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| **Joint Assessment Clinic (JAC) Parent/Carer Consent\******(only complete this section if this is a referral for the Joint Assessment Clinic.)*** |
|  [ ]  The reasons for this referral have been explained and I fully understand them.[ ]  I consent to my child being referred to the Joint Assessment Clinic.[ ]  I understand that a referral to the Joint Assessment Clinic could result in further assessment for Autism.[ ]  I agree to assessment information being shared between NHS staff, Education Staff and the person who referred me, if different. [ ]  I consent for my contact details to be sent to Contact Ealing (an external charity) to offer my family support while we are waiting for this assessment. [ ] I have been given the information leaflet that explains what the Joint Assessment Clinic is about |
| **Parent/carer Name:** |  |
| **Parent/carer Signature:** |  |
| **Date:** |  |

**APPENDIX 2: STAMMERING REFERRAL SCREENER FOR CHILDREN AGED 7+**

*Please note that we are no longer accepting referrals for children aged 7+ unless there is evidence that the child’s stammer has an impact on their speaking confidence, well-being, peer relationships or the level of parental concern. Please complete the following form to provide further information about this.*

*If your referral is rejected, we will signpost you to other sources of information that will provide support.*

1. **To be completed with the child: \***

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|  | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** |  |
| They use tricks and avoidance behaviours to deal with stammering |  |  |  |  |  |  |  |  | They use helpful strategies to manage their stammer. |
| They feel uncomfortable when speaking |  |  |  |  |  |  |  |  | They feel comfortable when speaking |
| They try to hide their stammer |  |  |  |  |  |  |  |  | They feel OK and talk openly about stammering |
|  They feel bad about themselves |  |  |  |  |  |  |  |  | They feel good about themselves |

1. **To be completed with the parent/carer:\***

How concerned are you about the stammer currently? (Please circle/highlight the number)

1 2 3 4 5 6 7 8 9 10

(Least concerned I’ve ever been) (Most concerned I’ve ever been)

How do you currently respond to your child when they stammer?

1. **Class teacher observations of child and their peer relationships:\***

(Comment on participation in class across a range of subjects, conversations with peers and friends including in the playground)

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| APPENDIX 3: FEEDING REFERRAL FOR SPEECH & LANGUAGE THERAPY*Please complete all fields that contain \* for the referral to be accepted* |
| **Medical diagnosis including birth history and feeding history:** |
| **What are the concerns about eating and drinking?\*** (please tick all that apply): |
| **☐** | change in alertness during mealtimes e.g. sleepy, anxious, distressed, crying |
| **☐** | during or after food, drink or medication child is coughing or choking (choking makes no noise)  |
| **☐** | changes to respiratory sounds or voice when eating and drinking e.g. wheezing, gurgling, wet voice |
| **☐** | changes in colour or breathing e.g. going red or blue in the face; rapid or slow breathing |
| **☐** | eyes widening; tears, excessive blinking or grimacing when eating or drinking |
| **☐** | repeated chest infections and/or pneumonia or aspiration |
| **☐** | difficulty with eating/swallowing certain food, drink or medication e.g. more than two swallows to clear food from the mouth; difficulty moving food around the mouth |
| **☐** | faltering weight (significant weight loss or failure to put on weight) |
| **☐** | signs of dehydration (e.g. very dry skin, reduced frequency of passing urine, few or no tears when crying, constipation, dark coloured urine) |
| **☐** | excessive dribbling/loss of food or liquids while eating/drinking |
| **Describe a typical day of eating and drinking for your child** |  |