****Child Health Service referral form****

**Speech and Language – Preschool/Early Years Communication**

**(not to be used for feeding referrals)**

**Before completing this referral form, please refer to the Yellow Pathway Preschool/Early Years Speech and Language Referral Criteria to help you judge if a referral is required yet in relation to the child’s age.**

**Please complete all boxes and please make sure you have consent from parents/legal guardians. We cannot accept referrals without consent.**

**If your referral does not meet criteria or if it is not completed with sufficient detail, it will be rejected.**

**If you are referring a child who is due to start school in this calendar year, please ensure your referral reaches us by 1st May or we will not be able to accept it.**

\*Required field

**General information**

|  |  |  |  |
| --- | --- | --- | --- |
| \*Date of referral  |  | \*Child’s date of birth |  |
| \*Child’s first name |  | \*Child’s family or last name |  |
| \*Name child likes to be known by |  | NHS Number (if known) |  |
| \*Child’s ethnicity |  | \*Child’s home language(s) |  |
| \*Name of parent/carer/guardian with parental responsibility  |  |
| \*Email of parent/carer for appointments, reports and information to be sent  |  |
| \*Address where the child lives  |  |
| \*Contact number for parent /carer |  |
| Name of second parent that has legal responsibility (if applicable) |  |
| Relationship to parent listed above  |  |
| Address of second parent/carer if different to listed above  |  |
| Contact number and email of second parent/carer |  |
| \*Is interpreter needed for appointments– if yes please state language? |  |
| \*Relevant medical history/diagnoses: |  |

**Who else works with the family or child?**

|  |  |
| --- | --- |
| \*GP’s name and address (we can only accept referrals for children with GPs in the Medway CCG) |  |
| Hospital doctor’s name and address if applicable. |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Service | Name (if known) | Service | Name (if known) |
|  | Speech and language therapy |  |  | Dietitian |  |
|  | Occupational therapy |  |  | Learning disability nurses  |  |
|  | Physiotherapy |  |  | Community nurses |  |
|  | Podiatry |  |  | School nurse |  |
|  | Health Visitor  |  |  | Special needs nursery  |  |
|  | Child and adolescent wellbeing service (NELFT) |  |  | Ophthalmologist  |  |
|  | Audiology |  |  | Educational Psychology |  |
|  | Behaviour support |  |  | Early Help |  |
| Other – please state: |

**Early Education Provider**

|  |  |
| --- | --- |
| \*Name and address of nursery or childminder |  |
| \*Contact person name and email address |  |
| \*Contact number  |  |

**Safeguarding**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| \*Does the child have a child protection plan? |  |  |
| \*Is the child a ‘child in need’? |  |  |
| \*Is the child a ‘looked after child’? |  |  |
| \*Has early help been initiated? |  |  |
| Any further information regarding safeguarding  |  |
| Social worker’s name and contact details  |  |

**Consent**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| \*Do parents/carers consent to referral to the child health service?Please note this could include to services in our team, in addition to speech and language therapy, if deemed appropriate at triage, including OT/physio/dietitian.  |  |  |

|  |  |
| --- | --- |
| \*Referrer’s name |  |
| \*Referrer’s role |  |
| \*Referrer’s address |  |
| \*Referrer’s email address  |  |
| \*Referrer’s phone number |  |

**Pathway specific questions**

|  |  |  |  |
| --- | --- | --- | --- |
| Has the child previously had speech and language therapy assessment?  | Yes | No | Unsure |
|  |  |  |
| If yes – please give details and enclose report if from another service or private provider |  |

|  |  |
| --- | --- |
| Does the child | Mark any that apply |
| Already have an EHCP with speech and language therapy intervention specified? |  |
| Require assessment for advice towards EHCP? |  |
| Have an acquired head or brain injury? (e.g. from a stroke, brain tumour, Road Traffic Accident): |  |
| Have a neurological or genetic diagnosis (e.g. cerebral palsy, down syndrome,)? |  |
| Have a degenerative/progressive illness? |  |
| Appear to be a selective communicator? |  |
| Have a cleft lip and palate? |  |
| Have a voice disorder? (must have been seen by ENT before a referral to our team, Please include ENT report) |  |
| Have a permanent bilateral moderate to profound hearing loss? If yes please state in the “who else works with the child” section, which Teacher of the Deaf is involved with the child, and if there is involvement from the cochlear implant team. Please also include the most up to date audiology report with this referral. |  |
| Have any hearing difficulties? (if does not meet criteria for hearing box above to be ticked) |  |

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| What are your **main concerns**? Why are you referring this child? |  |
| **Please comment on each of the following areas, considering the following prompt questions to help you. Please provide as much detail as possible in each section.**  |
| **Attention and listening**Does the child respond to their name? Stay to an activity for any length of time? Join in with group activities?  |  |
| **Play**What does the child play with? How do they play? Do they let others join their play? Do they play imaginatively? Prefer to play alone? Is their play repetitive? |  |
| **Understanding of language**Does the child respond to instructions? (single words/2 key words/longer instructions?) Please give examples where possible.Do they need additional cues such as pointing or gesture in order to follow instructions successfully? Do they understand out of context?Does the child understand simple conversation? |  |
| **Use of language**Vocabulary- what words can the child use? Are they joining words together (e.g. 2 word phrases/3 word phrases/longer phrases and sentences)? Do they confuse word order? Please provide examples of what you have heard the child say. |  |
| **Social communication skills**Does the child show desire to communicate? Make appropriate eye contact? Share enjoyment with others? Take turns? Use additional means to communicate such as gesture and pointing? Does the child appear to be a selective communicator i.e. they communicate freely in some situations but not in others? |  |
| **Speech Sounds**Is speech hard to understand? Does the child miss sounds off words? Say the same word differently each time they say it? Make errors with vowel sounds? Have a very limited range of consonant sounds? Please give some examples of the sound errors they make.Is the child understood by others? (some/most/all/ none of the time) |  |
| **Fluency (stammering/stuttering)**Is the child dysfluent? (do they stammer?) If yes- How long has this been going on? Is there any family history? Does it happen all the time or come and go?Is the child repeating sounds/syllables? Do they “get stuck” trying to produce words? Do they lengthen sounds? Do they avoid certain sounds or words? |  |

|  |  |
| --- | --- |
| **Is the child displaying any worrying behaviours? If yes please give details.****Does the child seem aware or frustrated by their difficulties?** |  |
| **Does the child have any sensory difficulties? If yes please give details** Consider for example response to sound/touch/texture/smell/taste/light/movement (seeking out or avoiding certain activities), the child’s activeness e.g. preference to jump/climb/spin etc or to avoid these activities. |  |
| **What impact are the child’s difficulties having on their everyday life, and that of their family? Please comment on:** |
| Participation in daily activities (include learning activities, nursery routines, play and home life) |  |
| Relationship with peers: |  |
| Emotional wellbeing: |  |

**Please email your completed form to:**

**medch.childrenscommunity@nhs.net**