**SPEECH AND LANGUAGE THERAPY SERVICE REFERRAL FORM**

**Information to support your referral can be found at the back of this referral form**

**PLEASE NOTE: A referral can only be accepted if ALL sections are completed, with detail of the functional impact of the child’s speech, language and communication needs. Consent from the person with parental responsibility for the child must be included. *INCOMPLETE FORMS WILL BE RETURNED.***

**Child’s details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Child**  |  | **Date of Birth** |  |
| **Address** |  | **Postcode** |  |
| **Contact Numbers**  |  |
| **Parent/ carer name(s)** |  |
| **Do parents/ carers have any literacy, learning or communication needs?**  | **Yes/ No** |
| **Languages (and dialect) spoken in the home** |  | **Interpreter needed?**  | **Yes\*/ No** *\*Interpreter Language/ Dialect required:* |
| **GP Name**  |  | **GP Address** |  |
| **Education setting** |  |
| **Are parents/ carers ready to engage with services to support their child’s speech, language and communication needs?** | **Yes/ No\*** *\*If no, please provide details below* |

**Additional information:**

|  |
| --- |
| **Please provide information regarding:*** **Referrals to other services made or planned, plus date of referral e.g. Audiology, Paediatrics, Woodbridge SEND Service, and Behaviour Support.**
* **Relevant information regarding the involvement of these services or other outside agencies such as private therapists or relevant charities.**
* **Details of EHCP provision for this child (please send a copy of their final EHCP with this referral) or stage in EHCP process if applicable.**
 |
|  |

* **PLEASE CONSIDER THAT IF A CHILD IS KNOWN TO MULTI-DISCIPLINARY TEAMS, AN EARLY HELP ASSESSMENT (EHA) SHOULD BE IN PLACE TO SUPPORT THE TEAM AROUND THE CHILD.**
* **THE LATEST EHA/ EH REVIEW SHOULD BE SUBMITTED ALONGSIDE THIS REFERRAL FORM, AS APPROPRIATE, TO INFORM AROUND THE CHILD HOLISTICALLY BUT WILL NOT BE ACCEPTED AS A REFERRAL.**

**SPEECH, LANGUAGE AND COMMUNICATION DIFFICULTIES**

**Please ensure you have evidence and information regarding each area of concern regarding the child’s communication and outline the impact this is having on the child.**

|  |  |
| --- | --- |
| **Please tick which areas the child is experiencing difficulties with:** | **Please comment how these difficulties are affecting the child:** |
| **Attention and listening skills** *e.g. Ability to attend to an activity for an age appropriate length of time.* |  |
| **Early communication skills** *e.g. Turn taking, eye contact, pointing.* |  |
| **Ability to understand language***e.g. Following age-appropriate instructions, responding to their name* |  |
| **Ability to use language** *e.g. Use of words, signs, symbols, communication aids.*  |  |
| **Clearness of speech** | ***Referrer must complete speech sound norms checklist (page 7) in relation to typical speech sound errors, noting the age at which this would be an area of concern.*** |
| **Social interaction skills***e.g. Sharing interest, smiling, interacting with peers, initiating interactions, eye contact* | ***Referrer must complete social communication checklist (page 8) if this is a social communication referral.*** |
| **Stammering***i.e. Characteristics evident when speaking which impacts fluency.* |  |
| **Swallowing/ feeding** | ***Referrer must complete feeding and swallowing supporting information (page 9) for any referrals whereby there are these concerns.*** |
| **Strategies/ interventions undertaken/ planned** e.g. further assessment tools, education interventions. |
| **Additional notes/ information relevant to this referral** e.g. family support required to access the service, reported family concerns (not observed by referrer). |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WellComm Tool Information** ***(if applicable)*****Please start at the section for the child’s chronological age and work backwards, stopping the assessment when they score ‘green’.** **See EYCLDS referral criteria (pages 5-6) whereby the main concern is speech sounds or this is a re-referral.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of 1st screen | Age in months at time of 1st screen  | Section | Score out of 10 | Red/Amber/Green | Which activities from Big Book of Ideas have been shared and demonstrated? E.g. 3.4, 3.5 etc.  |
|  |  | 8 |  |  |  |
|  |  | 7 |  |  |  |
|  |  | 6 |  |  |  |
|  |  | 5 |  |  |  |
|  |  | 4 |  |  |  |
|  |  | 3 |  |  |  |
|  |  | 2 |  |  |  |
|  |  | 1 |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of 2nd screen (at least 12 weeks later) | Age in months at time of 2nd screen  | Section | Score out of 10 | Red/Amber/Green | Comments  |
|  |  | 8 |  |  |  |
|  |  | 7 |  |  |  |
|  |  | 6 |  |  |  |
|  |  | 5 |  |  |  |
|  |  | 4 |  |  |  |
|  |  | 3 |  |  |  |
|  |  | 2 |  |  |  |
|  |  | 1 |  |  |  |

**ASQ-3/ ASQ SE scores *(if applicable)*****Please include relevant scores here:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Section | Score | White/ Grey/ Black |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| Additional narrative as applicable: |

 |

**CONSENT FORM**

**Please note written or verbal consent must be obtained from the person with parental responsibility for the child, as well as acknowledgement that they are ready to access support for their child through the service.**

**CONSENT FOR REFERRAL TO THE SPEECH AND LANGUAGE THERAPY SERVICE**

**As the person with parental responsibility for the child named below, I give consent for:**

* My child to be referred to the Speech and Language Therapy (SaLT) service by the named person below.
* My child to access and attend appointments with the SaLT service, as required during the period of care following this referral.
* Communications from the SaLT service via digital communication (text message), phone or letter.
* The SaLT service to liaise and consult with other people involved with my child’s care, as required to support their speech, language and communication needs.
* The SaLT service to share information with other services involved with my child, in both verbal and written formats.

Verbal consent can be gained by health professionals, but all other referrers need to obtain written consent for this referral to be accepted:

|  |  |
| --- | --- |
| **Child’s name:** |  |
| **Parent/ carer name:**  |  |
| **Relationship to child:**  |  |
| **Verbal consent** *(only for health professionals):*  | **Yes** **No** (referral will not be accepted) **N/A** |
| **Written consent** *(parent/ carer to sign):* |  |
| **Date:**  |  |

**Referral made by:**

|  |  |
| --- | --- |
| **Referrer’s name:** |  |
| **Signature:**  |  |
| **Job title:**  |  |
| **Work address:** |  |
| **Telephone contact:** |  |
| **Email contact:** |  |
| **Date of referral:**  |  |

**What’s next?**

**Please take a copy and send this referral via email to:** paedcommtherapyreferrals@boltonft.nhs.uk

**Please remember to include a copy of this child’s final EHCP, and latest Early Help Review if appropriate, if these are not sent but are applicable to this child, then the referral will be rejected.**

**The child’s parent/ carer will then receive communication from the SaLT service via telephone, digital or paper letter, with further information regarding accessing their initial appointment with the SaLT service.**

**Referral criteria for the Early Years Communication and Language Development Service (EYCLDS)**

*Before making the referral children should have accessed the following from the pathway:* [*https://www.boltonstartwell.org.uk/resources/every-child/4*](https://www.boltonstartwell.org.uk/resources/every-child/4)

***Don’t forget you can contact EYCLDS at any point for advice and guidance on 01204 338349***

Early Years Communication and Language Development Service (EYCLDS)
0-19 Service
Oxford Grove Start Well Centre
49-55 Shepherd Cross Street
Bolton BL1 3BY
01204 338349/ 338182

|  |
| --- |
| **Every Child Offer*** High quality adult interaction and language rich environments wherever the child spends time.
* Consistent use of the 5 Golden Rules of Early Language and Communication Development by parents/ carers and educational setting.
* Assessment tools:
	+ Ages & Stages Questionnaire – 3 (ASQ-3)
	+ Ages & Stages Questionnaire – SE (ASQ-SE)
	+ Communication & Language Journey
	+ Newborn Behavioural Observations
	+ Early Years Foundation Stage (EYFS)
 |
| **Getting Help from those already involved:*** Complete a WellComm Assessment
	+ Green = Continue with ‘Every Child’ offer.
	+ Amber = Carry out appropriate activity from the Big Book of Ideas (BBI) with family and reassess after 3 months. Consider signposting to a [Let’s Get Talking group](https://www.boltonstartwell.org.uk/downloads/file/754/referral-for-lets-get-talking-6-week-online-sessions-).
	+ After reassessment, if child continues to score Amber, continue with reassessment and contact EYCLDS for advice and guidance.
	+ Red = Carry out appropriate activities from BBI, plus contact EYCLDS for specific Information, Advice and Guidance (IAG).
	+ Other interventions include: Nursey Narrative, EYBIC.
 |

**Refer to EYCLDS if the child meets the below criteria, continuing with the intervention (BBOI activities) until the child has been seen.**

|  |
| --- |
| **Getting More Help from additional agencies:**Criteria summary:* Child is between 18 months and 4 years.
* Child is presenting with language and communication difficulties and has scored RED on their review WellComm.
* It can be demonstrated that the activities and advice from the BBI has been implemented between WellComm assessments.

**If there are concerns regarding the child's social communication skills, please contact EYCLDS prior to making the referral on 01204 338349.****Requests received that have not demonstrated evidence of two WellComm assessments and consistent use of the BBOI interventions will be rejected.**  |

|  |
| --- |
| **How to access EYCLDS:** |
| **What information to include to access EYCLDS…****“In addition to a relevant holistic assessment”** for the child, information about strengths and needs in the following areas should be provided in the **Speech, Language and Communication** section of the single agency referral form:* Attention and Listening
* Play and social skills
* Understanding
* Talking and speech sounds
* Feeding/swallowing issues
* Information about what steps have been made to address these concerns to date, e.g. WellComm scores and activities shared with family, family attended “Let’s get Talking”.

**NB: Bilingual requests** - please state **ALL other languages spoken in the home** regardless of need for interpreters. We need this information to assess the child in their first language, as well as in their second language. This means that we will need to book an appropriate interpreter to help the Speech and Language Therapist complete this assessment process. *Please specify if a child is already known to an independent or private Speech and Language Therapist (SaLT) and include their details in the other professionals involved section. This is so that liaison between SaLTs can take place, with parental permission.* |
| **Additional Important Information:** |
| * Where children are presenting with Social Communication difficulties, please contact EYCLDS prior to making the referral/ to discuss carrying out the WellComm assessment.
* The WellComm assessment should be completed with all children where there are concerns with their communication skills. If due to the child’s current level of ability it is not possible to complete the WellComm starting at the section for their chronological age, then sections 1 and 2 (observation-based) should be completed at a minimum.
* Where the communication concerns are specifically around speech sounds, or in the case of re-referrals, referrals will be accepted without needing 2 WellComm assessments to be completed 12 weeks apart, as per the guidance below.
* **Speech Sounds** - if it is clear all other areas of the child's language and social communication needs are developing typically, they may be seen by EYCLDS. One set of WellComm scores should be included to rule out delayed language development.
* **Re-referrals** - these children have previously met the criteria and have previously accessed the service. For these children, if it is clear that it is a re-referral and a small update on the progress the child has/hasn’t made since they last accessed the service is provided, they can access EYCLDS without evidence of WellComm scores.
 |

***Don’t forget you can contact EYCLDS at any point for advice and guidance on 01204 338349.***

# SPEECH SOUND DEVELOPMENT CHECKLIST

If the referral being made is for speech sound clarity, please consider the child’s abilities in relation to this speech sound development checklist. This **must** be completed for the referral to be accepted.

|  |  |  |  |
| --- | --- | --- | --- |
|  | AGE 3 YEARS |  |  |
|  | NOT A CAUSE FOR CONCERN | POSSIBLE CAUSE FOR CONCERN |  |
|  | Speech usually understood by family, but strangers may struggle. | Family members find speech difficult to understand most of the time.  |  |
|  | Using a range of consonant sounds. | Only using one consonant sound, e.g. uses /h/ to replace most consonants. |  |
|  |  |  |  |
|  | AGE 3 ½ - 4 ½ YEARS |  |  |
|  | NOT A CAUSE FOR CONCERN | POSSIBLE CAUSE FOR CONCERN (also consider above causes for concern) |  |
|  | Speech usually understood by family, but strangers may struggle. | Missing of beginnings of words e.g. car 🡪 ar, dog 🡪 og. |  |
|  | Fricative sounds: /f, v, s, z/, ‘sh’ may not be used yet and child may replace these sounds with a shorter sound e.g. sun 🡪 dun, house 🡪 hout. | Sounds ‘c/k’ and /g/ used to replace /t/ and /d/ e.g. teddy 🡪 keggy, dog 🡪 gog. |  |
|  | Sounds /t/ and /d/ used for ‘c/k’ and /g/e.g. coat 🡪 toat, girl 🡪 dirl. |  |  |
|  | Consonant ‘blends’ reduced e.g. spider 🡪 pider, dress 🡪 dess. |  |  |
|  | Interdental ‘lisp’ e.g. sun 🡪 thun or ‘slushy’ /s/ sound. |  |  |
|  | /r/ and /l/ replaced by /w/ e.g. red 🡪 wed, lip 🡪 wip. |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | AGE 4 ½ - 5 YEARS |  |  |
|  | NOT A CAUSE FOR CONCERN | POSSIBLE CAUSE FOR CONCERN (also consider above causes for concern) |  |
|  | Speech understood most of the time.  | Speech always difficult to understand. |  |
|  | Sounds such as ‘sh, ch, j, r, th, y’ not used clearly e.g. shoe 🡪 soo/doo, chair 🡪 tair, yellow 🡪 lellow. | The sounds /t, d, c/k, g, f, s/ not yet used correctly. |  |
|  | Consonant blends e.g. /tr, fl, st, sm/ not always used clearly e.g. flower 🡪 fwower, stop 🡪 top/dop. |   |  |
|  | Interdental ‘lisp’ e.g. sun 🡪 thun or ‘slushy’ /s/ sound. |  |  |
|  | /r/ and /l/ replaced by /w/ e.g. red 🡪 wed, lip 🡪 wip. |  |  |

**SOCIAL SKILLS QUESTIONNAIRE**

If the referral being made for a **social communication assessment**, please consider the child’s presentation in relation to this social skills questionnaire.

This **must** be completed for the referral to be accepted.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Never** | **Sometimes** | **Often** | **Always** | **Comments** |
| Engages in greetings/farewells |  |  |  |  |  |
| Uses age appropriate strategies for getting attention of others |  |  |  |  |  |
| Asks for help appropriately from others  |  |  |  |  |  |
| Makes eye contact during interactions |  |  |  |  |  |
| Maintains appropriate body position during conversations |  |  |  |  |  |
| Follows turn taking rules in interactions |  |  |  |  |  |
| Introduces appropriate topics of conversation |  |  |  |  |  |
| Asks appropriate questions during interactions |  |  |  |  |  |
| Shows an appropriate sense of humour during interactions |  |  |  |  |  |
| Appropriate facial expression to match situation  |  |  |  |  |  |
| Appropriate body language to match situation |  |  |  |  |  |
| Appropriate tone of voice to match situation |  |  |  |  |  |
| Adjusts personal space appropriate to the situation  |  |  |  |  |  |
| Knows how someone is feeling based on non-verbal cues |  |  |  |  |  |
| Reads the social situation correctly and behaves appropriately  |  |  |  |  |  |

**FEEDING AND SWALLOWING SUPPORTING INFORMATION**

|  |  |
| --- | --- |
| **Birth history** | *(e.g. born prematurely / birth injuries / health of baby at birth)* |
| **Early feeding history** | *(e.g. breast / bottle fed / tongue tie / reflux)* |
| **Current health and development** | *(e.g. any medical diagnoses, developmental delay, learning disability)* |
| **What food/ textures does the child enjoy?** |  |
| **What food/ textures does the child struggle with?** | *(include what happens when they are struggling)* |
| **Is the child following their expected growth / height trajectory?** |  |
| **Are there any signs of aspiration when the child is eating or drinking?** | *(e.g. coughing, spluttering, voice change, breathing difficulties, eye watering, facial colour change. Please specify)* |
| **Have there been any choking incidents?** | *(Please describe frequency, what happened, did the child require first aid/ ambulance/ hospital admission?)* |
| **Is the child having lower respiratory tract infections?** | *(Please provide dates and treatment required)* |
| **What has already been tried to support the child’s feeding skills?** |  |
| **Is the child on any regular medication?** |  |
| **Who else works with the child?**  | *(e.g. Dietitian/ Physiotherapist/ Occupational Therapist)* |