**Paediatric Speech and Language Therapy**

**Request for Involvement for pupils in College/Independent/Home School**

Please email this form to ccs-tr.slt@nhs.net

 and we will contact you to discuss the request for involvement.

|  |  |  |
| --- | --- | --- |
| **Young person’s full name:** | **Date of birth:** | **Today’s date:**  |
| **Ethnicity:** | **Age(y/m):**  | **Gender:** |
| **Full address:** |  |
| **Telephone:****Email:** | **Mobile:****Consent to contact via email: Y / N**  |
| **Home Language:** | Interpreter needed?Y / NLanguage required:  |
| **Main carer:****Relationship to young person:**  | **Other carers with parental responsibility:** |
| **GP name and address:**  | **School:**  | **Teacher and year group:** |
| **EHCP: Y / N**  | **Any known diagnoses:** |
| **Other professionals involved:** | **Please tick and state name/contact details if known** |
| SEND Specialist service (EP, specialist teacher)  | □ |
| Occupational Therapist  | □ |
| Physiotherapist | □ |
| Paediatrician | □ |
| Other? (Teacher of the Deaf, Private SLT, VI Teacher etc)  | □ |
| **Giving your consent****Parental Consent for SLT referral: Yes ☐ Signature of parent/carer ……………………………….**Cambridgeshire Community Services (CCS) NHS Trust would like to send text (SMS) messages for appointment reminders and to share useful health information. **I agree to receive text (SMS) messages Yes ☐ No ☐**We would like to send your letters or reports by email, which could include personal, sensitive data. If you select yes, we will not send your letters or reports in the post, we will email them to you instead. You will receive a verification email from TPP which you must reply to as confirmation that we have the right details. We cannot email you any information without this verification. **I agree to receive emails which could include personal information:** **Yes ☐ No ☐**Once any information has left our secure NHS email accounts, the security of the information is your responsibility.**Sharing information:**Are you happy for us to share your child’s record with other health services who are involved with your child’s care? **Yes ☐ No ☐**Are you happy for us to have access to the records held by other health services involved in your child’s care? **Yes ☐ No ☐**If we need to talk to other professionals involved with your child, e.g. play group or school staff, are you happy for us to share information with them?  **Yes ☐ No ☐** |

***Speech, Language and Communication Screening Tool***

**Is the young person you wish to refer:**

Spoken Language:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No  | Sometimes **please comment** |
| Able to formulate complex sentences? |  |  |  |
| Able to convey more complex ideas verbally e.g. telling stories/retelling events ? |  |  |  |
| Able to use some harder vocabulary?  |  |  |  |
| Use largely correct grammar e.g. correct pronoun/tense? |  |  |  |
| Have clear speech sounds e.g. not swapping/replacing sounds?  |  |  |  |

Understanding of language:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No  | Sometimes |
| Able to follow complex instructions e.g. those with multiple steps?  |  |  |  |
| Able to understand and answer complex questions e.g. why, how do you know, what would happen if… etc?  |  |  |  |
| Understand the meaning of harder vocabulary?  |  |  |  |

Social communication:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No  | Sometimes |
| Able to make/sustain friendships?  |  |  |  |
| Able to follow social rules e.g. maintaining eye contact, initiating conversations, taking turns in conversation?  |  |  |  |
| Able to consider the thoughts and feelings of others?  |  |  |  |

Classroom skills:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No  | Sometimes |
| Able to organise themselves e.g. having the correct equipment, punctuality and following timetables?  |  |  |  |
| Able to pay satisfactory attention in class?  |  |  |  |
| Have confidence e.g. to ask for help, to say what’s wrong? |  |  |  |

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| --- |
| **Are you concerned the young person may have a Stammer?** **Please describe and provide evidence of interventions/strategies that are currently being implemented. (We are not able to provide involvement if there is no evidence to demonstrate strategies or interventions that are currently in place).** **How long has the support been in place and what was the outcome of this or any previous intervention?** **Has the young person been known to the Speech and Language Therapy service before? If so, when?** **Parent’s level of concern about the issue you wish to make a referral for:**High Moderate Low**Have you spoken to the young person about this referral?** **Young person’s comments/views:** **Any additional concerns from parent/parent priorities:****What are you expecting from Speech and Language Therapy involvement?****What is the desired outcome from an SLT assessment or intervention?** |
| **Referrer details:**  |
| **Name:** |  | **Role:** |  |
| **Address:** |  | **Telephone:** |  |
| **Email:**  |

**To be completed by the Speech and Language Therapist:**

|  |
| --- |
| **Agreed action:** |
| Referral accepted: (Y/N) | Accepted for:  |
| **Next steps:**  |

|  |
| --- |
| **FOR OFFICE USE ONLY** |
| Therapist: |  |
| Referral accepted for: |  |
| Date of meeting:  |  |
| Caseload: |  |