**Children’s Speech and Language Therapy**

**Request for Involvement Form**

**Please refer to the Communication Trust Checklist before completing fields on this form. This can be found at:** [www.thecommunicationtrust.org.uk/media/363853/us\_checklist\_new.pdf](http://www.thecommunicationtrust.org.uk/media/363853/us_checklist_new.pdf)

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| --- | --- | --- |
| **Child’s Full Name:**  | **Date of Birth:** | **Today’s Date:** |
| **NHS Number:**  | **Age: y m** | **Gender: M / F** |
| **Address with Postcode:** | **Email:** |
| **Home Telephone:** | **Mobile:** |
| **Ethnicity:** | **Religion:**  | **Language:** | **Interpreter needed: Y/N** |
| **Main carer:****Relationship with child:** | **Other carers with parental responsibility:****Address if different:** |
| **GP Surgery:** | **Health Visitor:** |
| **Other relevant information** (cultural, social, home situation)**Has your child ever had a head injury (e.g. a blow to the head, a fall, a car accident) or illness (e.g. meningitis, a brain tumour, epilepsy)? Yes ☐ No ☐**  |
| **Giving your consent****Parental Consent for SLT referral: Yes ☐ Date request discussed with parent/carers.**Cambridgeshire Community Services (CCS) NHS Trust would like to send text (SMS) messages for appointment reminders and to share useful health information.**Parent agreement 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. **Parent agreement 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 ☐** |
| **Education/Nursery Setting: School Year:** |
| **☐ Mainstream School ☐ Pre-school/Nursery ☐ Special School ☐ Independent ☐****Is child making educational progress as expected? ☐ Yes ☐ No** **If no please specify:** |
| **EHCP: ☐ Yes ☐ No**  |
| **Inclusion coordinator/SENDCo name:**  | **Contact details:** |
| **Diagnosis or primary area of difficulty:** |
| **Other professionals involved** | **Please tick and state their name, if known.****Please attached any relevant reports** |
| Health Visitor (HV) | **☐** |  |
| SEND Specialist Service (EP, Specialist Teacher) | **☐** |  |
| Occupational Therapist (OT) / Physiotherapist (PT)/ Dietitian | **☐** |  |
| Paediatrician | **☐** |  |
| Teacher of the Deaf (TOD) / Visual Impairment Teacher | **☐** |  |
| **Describe how the child or young person presents using the headings below.**  |
| **Description of concern select as appropriate** | **Please describe your concerns and give examples** |
| **Speech (making sounds and using them in words)**  |  |
| **Receptive Language (understanding spoken language)** |  |
| **Expressive Language (using words and sentences)** |  |
| **Play and social interaction (with peers and adults)** |  |
| **Eating and Drinking (swallowing difficulties)** |  |
| **Stammering** |  |
| ***Please describe and provide evidence of interventions 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?******If previously seen by Speech and Language Therapy, when was the last contact? Please attach any relevant reports.******Do the child’s parents have concerns and what are they?******What are the child’s views (if they are able to communicate this):******What is the desired outcome from any SLT assessment, advice or intervention?***  |
| **Safety**Are there any safety issues/ risks for the child or others (arising from child’s needs)? Please specify: |
| **Referrer details** |
| Name: |  | Job Role: |  |
| Address: |  | Telephone: |  |
| Email: |  |

Please return this form, with any available reports, for discussion at an agreed planning meeting. This is usually a virtual meeting but can be face-to-face.

**Named Therapist: Date discussed:**

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