**Paediatric Speech and Language Therapy**

**Request for Involvement for secondary aged pupils**

Please complete this form and arrange to speak to your named therapist in order to discuss a possible referral to the Paediatric Speech and language Therapy Team. If CYP is not in school please email to CCS-TR.therapyreferrals@nhs.net

|  |  |  |
| --- | --- | --- |
| **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)  | □ |
| **Parent/Carer consent:** I give consent for this young person to be seen by the Speech and Language Therapist (SLT)I understand that this may involve: Assessment and individual or group sessions during school time without parents/carers present Observation within the classroom The SLT will speak to and share relevant information with anyone else working with this young person, e.g. teacher, PaediatricianParent/Carer Signature ……………………….. Date:  |

**Speech, Language and Communication Screening Tool: Secondary School**

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

**Spoken Language:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No  | Sometimes |
| Have difficulty formulating complex sentences? |  |  |  |
| Struggle to convey more complex ideas verbally e.g. telling stories/retelling events ? |  |  |  |
| Only use simple vocabulary?  |  |  |  |
| Use immature grammar e.g. incorrect pronoun/tense? |  |  |  |
| Have unclear speech sounds e.g. swapping/replacing sounds?  |  |  |  |

**Understanding of language:**

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

**Social communication:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No  | Sometimes |
| Have difficulty making/sustaining friendships?  |  |  |  |
| Finds it difficult to follow social rules e.g. maintaining eye contact, initiating conversations, taking turns in conversation?  |  |  |  |
| Have difficulty thinking about the thoughts and feelings of others?  |  |  |  |

**Classroom skills:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No  | Sometimes |
| Have difficulty organising themselves e.g. having the correct equipment, punctuality and following timetables?  |  |  |  |
| Struggle to hold attention in class?  |  |  |  |
| Have low confidence e.g. doesn’t ask for help?  |  |  |  |

**Educational Needs:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No  | Sometimes |
| Have difficulties in most areas of the curriculum?  |  |  |  |
| Need additional support in class for most lessons?  |  |  |  |

|  |
| --- |
| **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: |  |