

**Children’s Speech and Language Therapy**

**Request for Involvement Form**

**Please refer to the Communication Trust Checklist before completing all 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)

**If appropriate, the attached screening tools can be used.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Child’s Full Name:** | | | **Date of Birth:** | | | | **Today’s Date** |
| **NHS Number:** | | | **Age: y m** | | | | **Gender: M / F** |
| **Address with Postcode:** | | |  | | | | |
| **Home Telephone:**  **Email:** | | | **Mobile:**  **Consent to contact via email Y / N** | | | | |
| **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)  **Parental Consent for SLT referral: Yes ☐ Signature of parent/carer ……………………..**  **Do parents/carers consent to share this information with other professionals from health and education?** **☐ Yes ☐ No**    **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 ☐** | | | | | | | |
| **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/Senco 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) | | **☐** | |  | | | |
| Paediatrician | | **☐** | |  | | | |
| Teacher of the Deaf (TOD) / Visual Impairment Teacher | | **☐** | |  | | | |
| **Describe how the child or young person presents using the headings below.** | | | | | | | |
| **Description of Concern(s)** | | | | | | **Please rate your level of concern on a scale of 1 – 5**  **(0 = no concern, 5 = high)** | |
| **Speech (making sounds and using them in words)** | | | | | | **0 1 2 3 4 5** | |
| **Receptive Language (understanding spoken language)** | | | | | | **0 1 2 3 4 5** | |
| **Expressive Language (using words and sentences)** | | | | | | **0 1 2 3 4 5** | |
| **Play and social interaction (with peers and adults)** | | | | | | **0 1 2 3 4 5** | |
| **Eating and Drinking (swallowing difficulties)** | | | | | | **0 1 2 3 4 5** | |
| **Stammering** | | | | | | **0 1 2 3 4 5** | |
| **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.***  **Parent’s level of concern about the issue for which referral is being made:**  High Moderate Low  **Additional views of parent / different areas of concern** **that they identify:**  **What are the child’s views (if they are able to communicate this):**  **What are you expecting from our involvement? (This could be advice or a specific package of care)**  What is the **desired outcome** from an SLT assessment 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, to your link therapist for discussion at an agreed planning meeting. This can be face-to-face or on the telephone.

**Name of Link Therapist: Date discussed:**

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**To be completed by the speech and language therapist in collaboration with the referrer**

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| --- | --- | --- |
| **Pathway** |  | **Comments and agreed next steps** |
| **Speech** | **☐** |  |
| **Language** | **☐** |  |
| **Social Communication** | **☐** |  |
| **Voice** | **☐** |  |
| **Fluency** | **☐** |  |
| **Eating/drinking** | **☐** |  |