Please note: **ALL** boxes on this form must be fully completed in order for the request for assessment to be processed. Any incomplete forms will be returned to the requester.

**EARLY YEARS**

**Bury Children’s Speech and Language Therapy –**

**Request for Assessment**

**Child/Young Person’s details**

|  |  |
| --- | --- |
| Name: | Date of birth: |
| Gender: | NHS number: |
| Address: | GP: |
| Parent/Guardian 1: Please provide name/address/contact numberParental responsibility? Yes / No | Parent/Guardian 2: Please provide name/address/contact numberParental responsibility? Yes / No |
| Languages spoken at home: | Interpreter required? Yes / No |

**Safeguarding**

|  |
| --- |
| Please tick if the child is subject to any of the following?* Child Protection Plan
* EHFS Plan (Early Help Family Support Plan)
* CIN action plan (Child In Need)
* TAF action plan (Team Around the Family)
 |
| If ‘**yes**’ to the above please provide name and contact details of key person: |
| Is this a **Looked After Child?** Yes / No If **No,** please skip to the Health section and continue  |
| Person with parental responsibility |  |
| Consent for referral given by |  |
| Social Worker details: Name, address, contact number & placing authority required |  |
| Legal Status |  |
| Foster Carer / Carer name, address & contact number |  |
| Who can attend appointments? |  |
| Restrictions: Regarding information sharing during appointments and in reports / report circulation |  |

**Health**

|  |  |  |
| --- | --- | --- |
| Has hearing been checked?  | Date(s) | Result: |
| Has vision been checked? | Date(s) | Result: |
| Please tick any other professionals involved and provide names and contact information if known:* Audiology
* ENT
* Family Support Worker
* School Nurse
* Occupational Therapist
* Physiotherapist
* Paediatrician
* Social Worker
* Other
 |

**Education**

|  |
| --- |
| Name, address & telephone number of nursery / pre-school (if appropriate): |
| Please give details of the current level of support: e.g. SEN support / EHCP |
| Current developmental tracking information: please indicate whether these are above or below age expectations |
| Has the child been seen by any of the following services:* Educational Psychology
* Additional Needs Team

Please attach a copy of any paper work related to these assessments |

Has a Wellcomm Assessment been completed? Please complete the table below and attach any outcome forms.

**Please note: if the referral is from Health Visitors / Community Nursery Nurses:**

This section must be completed prior to referring, if it has not been possible to complete a WellComm please describe why not.

|  |  |  |
| --- | --- | --- |
| Section completed: | Score(e.g. red/amber/green) | Outcome (Which ‘Big Book of Ideas’ handouts have been provided and to who?) |
|  |  |  |

**Reasons for this request for assessment**

|  |
| --- |
| What is the requester’s main concern?  |
| What is the parent/carer’s main concern? |
| Please comment if you know what the child/young person’s main concern is. |

**Please comment on strengths and needs and explain how they affect the child/young person: Please note ALL boxes must be completed.**

|  |  |  |
| --- | --- | --- |
| **The child/young person’s ….** | **Strengths** | **Needs** |
| **Attention and listening skills**e.g. interest in toys, interest in adult led activities |  |  |
| **Understanding of spoken language**e.g. following instructions, answering questions |  |  |
| **Use of spoken language**e.g. length of sentences, use of words |  |  |
| **Use of speech sounds**e.g. who can the child be understood by, any sounds which the child has difficulty saying |  |  |
| **Social interaction**e.g. interaction with other children/adults, eye contact |  |  |
| **Fluency**e.g. stammering / repetitions of sounds/words |  |  |
| Any other areas of concerns about the child/young person’s development? |

**Requester details**

|  |  |
| --- | --- |
| Name: | Address and contact number: |
| Job Title: |
| Would you like a copy of the appointment letter? |
| If appropriate, we will offer supported intervention that would need to be delivered by a member of staff at school. Please provide a named contact for this: |

**Consent**

 **Parent/Carer Signature** **Date**

|  |  |  |
| --- | --- | --- |
| I confirm that I am the parent / guardian with parental responsibility, or foster carer with delegated authority, and that I consent to this referral to the service for assessment and treatment.I consent to liaison with other professionals relevant to my child’s care. |   |  |

 **Requester Signature** **Date**

|  |  |  |
| --- | --- | --- |
| I confirm that I have discussed this request for assessment with the parent / guardian and that they have given their express consent to this request for assessment. I am aware / have explained to the parent/guardian that this request for assessment is subject to triage and that the child may be signposted to another agency better able to meet the child’s needs, or further information may be requested before the referral to the service is accepted. |  |  |

**Please send completed form to:**

**Single Point of Access team (SALT Referral),**

**Textile Hall**

**Manchester Road**

**Bury**

**BL9 0DG**

**Tel: 0300 323 3316**

**Email:** **spoa.fax@nhs.net**