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**Speech and Language Therapy Request for Assessment – School Age**

**Please note:** All referrals need to be discussed with the school therapist prior to being submitted. **ALL** boxes on this form must be fully completed for the referral to be accepted.

Page 2 needs to be completed by parent/carer of the child being referred.

|  |  |  |
| --- | --- | --- |
| Name: | NHS no: | Date of Birth: |
| Address: | | |
| Phone Number: | | |
| GP Surgery: | | |
| Ethnicity: | | |
| Language(s) spoken at home: | | |
| School: | | |

|  |
| --- |
| Background Information: *Previous SALT Input, Diagnosis, Professionals Involved,* |
| How can we help? *Who is concerned, what are the concerns, what has been tried, what is working/not working, how is it impacting the child?*  *If your concerns are related to speech sounds, the speech screen must be completed and attached to this referral. If this is not included, the request for assessment will NOT be accepted.* |
| Safeguarding? *CIN? LAC? TAF? CP? Details of SW involved, Virtual Schools caseworker* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Details** | Name: | | Role: |
| Phone: | Email: | | |
| **If this box is not completed, the request for assessment will NOT be accepted.** | | | |
| Therapist consulted: | | Consultation Date: | |
| Signature: | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | NHS no: | Date of Birth: | | |
| Family Information: *Name of parent/carer, who lives at home* | | | | |
| Family History of Speech Language and Communication Needs? | | | | |
| Medical Information: eg: *birth history, diagnoses, hospital admissions, concerns with hearing/vision, professionals involved with care.* | | | | |
| What is the impact of your child’s difficulties on day-to-day functioning? | | | | |
|  | | | | |
| **Parent/Carer Consent** (we cannot accept a request for assessment without this) | | | | |
| I agree to this referral to Speech and Language Therapy. | | | YES | NO |
| I give permission for my child to be seen by a student SLT under supervision | | | YES | NO |
| I give permission for relevant information to be shared with other professionals | | | YES | NO |
| I give permission for my child to be assessed in school in liaison with school staff. | | | YES | NO |
| Parent/Carer Name:  (print in BLOCK CAPITALS) | | | | |
| Parent/Carer signature: | | | | |

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*Please send completed forms to: Single Point of Access team (SALT Referral), Textile Hall, Manchester Road, Bury, BL9 0DG or SPOA.fax@nca.nhs.uk*

**Speech and Language Therapy Request for Assessment – School Age**

* To be completed by parents/carers

Age