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.

**SCHOOL AGED**

**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 number  Parental responsibility? Yes /No | Parent/Guardian 2: Please provide name/address/contact number  Parental responsibility? Yes / No |
| Parents email address: | |
| Languages spoken at home: English | 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 / delegated authority |  |
| 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?  *An eye test is not required for the referral to be made* | Date(s) (if known) | Result (if known): |
| 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 school: |
| Please give details of the current level of support: e.g. SEN support / EHCP |
| Current education attainment levels: 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 |

* **Specialist Speech and Language Therapy assessment is only indicated if targeted intervention has been implemented prior to this request for assessment.**

**Please note: targeted interventions (formal or informal) must be evidenced in order for this request for assessment to be accepted.** *Example interventions include: Wellcomm Big Book of Ideas, Word Aware, Time to Talk, vocabulary group etc.*

**Please note: parents/carers should get this section completed by school prior to submitting the request for assessment.**

|  |  |  |
| --- | --- | --- |
| Targeted speech and language intervention | Describe what you are doing and how you are doing it | Outcome  (e.g. progress made) |
|  |  |  |

**Reasons for this request for assessment**

|  |
| --- |
| What is the school’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 can provide 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@nca.nhs.uk**