Please note: **ALL** boxes on this form must be fully completed 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 |
| Parents email address:  |
| 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 |  |

**Reasons for this request for assessment:**

|  |
| --- |
| Are there concerns about communication and language? Yes/No (if yes, please detail)**If yes, Nurseries/ Preschools must also complete the ‘Wellcomm Information Form’ (see p.5)** |
| Are there concerns about pronunciation of speech sounds? Yes/No (if yes, please detail)**If yes, and the child is using 2-3 words together, Nurseries/ Preschools must also complete and attach the Speech Sound Screen:** <https://theburydirectory.co.uk/speech-sound-screen-toolkit>  |
| Are there concerns about fluency/ stammering? Yes/No (If yes, please detail) |
| Are there any other concerns about the child’s development? Yes/No (if yes, please detail) |

**Please detail current targeted intervention in place for the child their progress:**

|  |
| --- |
|  |

**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 list any other professionals involved and provide names and contact information if known: |

**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: |

**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 in the child’s nursery/ preschool. 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**

**Nurseries and Preschools: Wellcomm Information Form**

**Please note: if it has not been possible to complete a Wellcomm assessment, please obtain parent consent to contact the service on 01617242092 to discuss making the referral with the triage team.**

**A Wellcomm assessment can be completed across several sittings. If the child is finding it difficult to engage, consider assessing at a different time or starting from an earlier section.**

1) Has a Wellcomm assessment been completed? Yes/ No - Please include information on **all** sections assessed:

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Child Age at Time of Screen (Years and months)** | **Section**  | **Score: (Red/ Amber/ Green)** |
|  |  |  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**If the child scores:**

* **Amber** or a **single red,** please complete relevant sections of the Big Book of Ideas and review in 3 months’ time (please detail in 2)
* **Red** for their age section and **red** for the age section below, **please refer to SALT** and complete relevant sections of the Big Book of Ideas.

2) Has a 3-month Wellcomm review been completed? Yes/No

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Child Age at Time of Screen (Years and months)**  | **Section**  | **Score: (Red/ Amber/ Green)** |
|  |  |  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**At the 3-month review, if the child scores:**

* **Amber,** please continue with the Big Book of Ideas activities and review in 3 months
* **Red – refer to SALT**