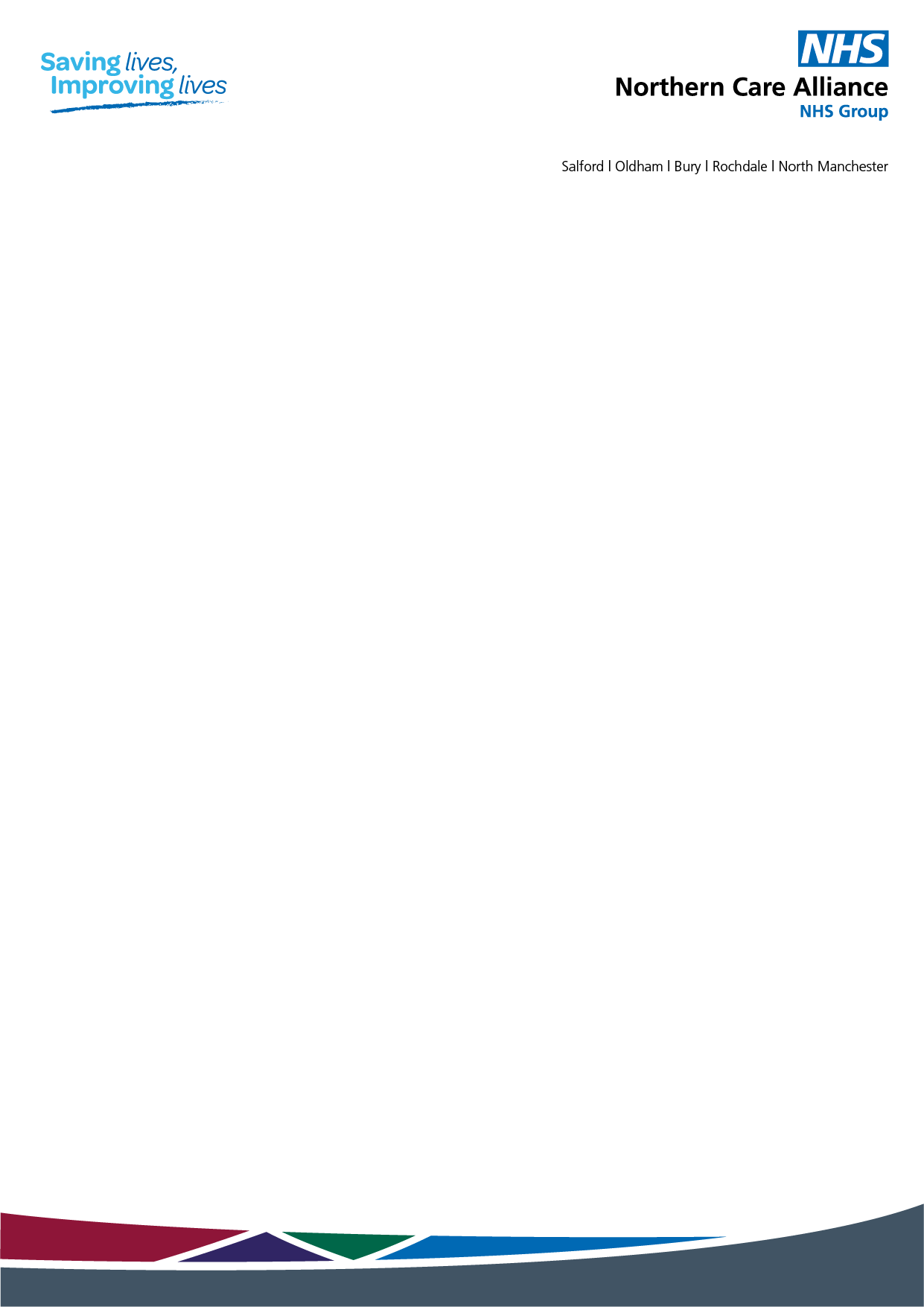
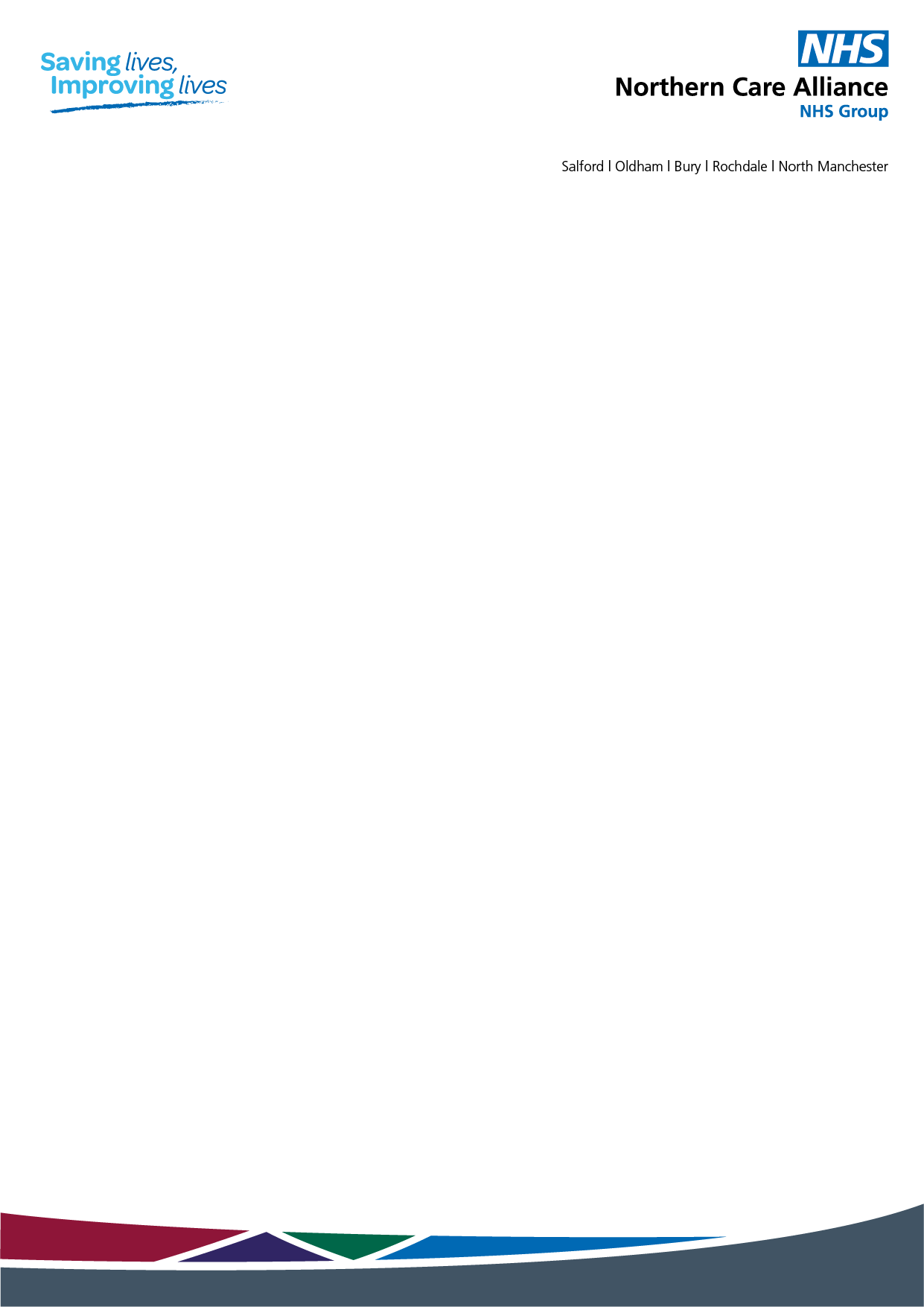
|  |
| --- |
| Background Information: *Previous SALT Input, Diagnosis, Professionals Involved,* |
| How can we help? *Who is concerned, what are the concerns, what has been tried, what is working/not working, how is it impacting the child?* |
| Safeguarding? *CIN? LAC? TAF? CP? Details of SW involved, Virtual Schools caseworker* |



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

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

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer Details | Name: | | Role: |
| Phone: | Email: | | |
| Therapist consulted: | | Consultation Date: | |
| Signature: | | | |



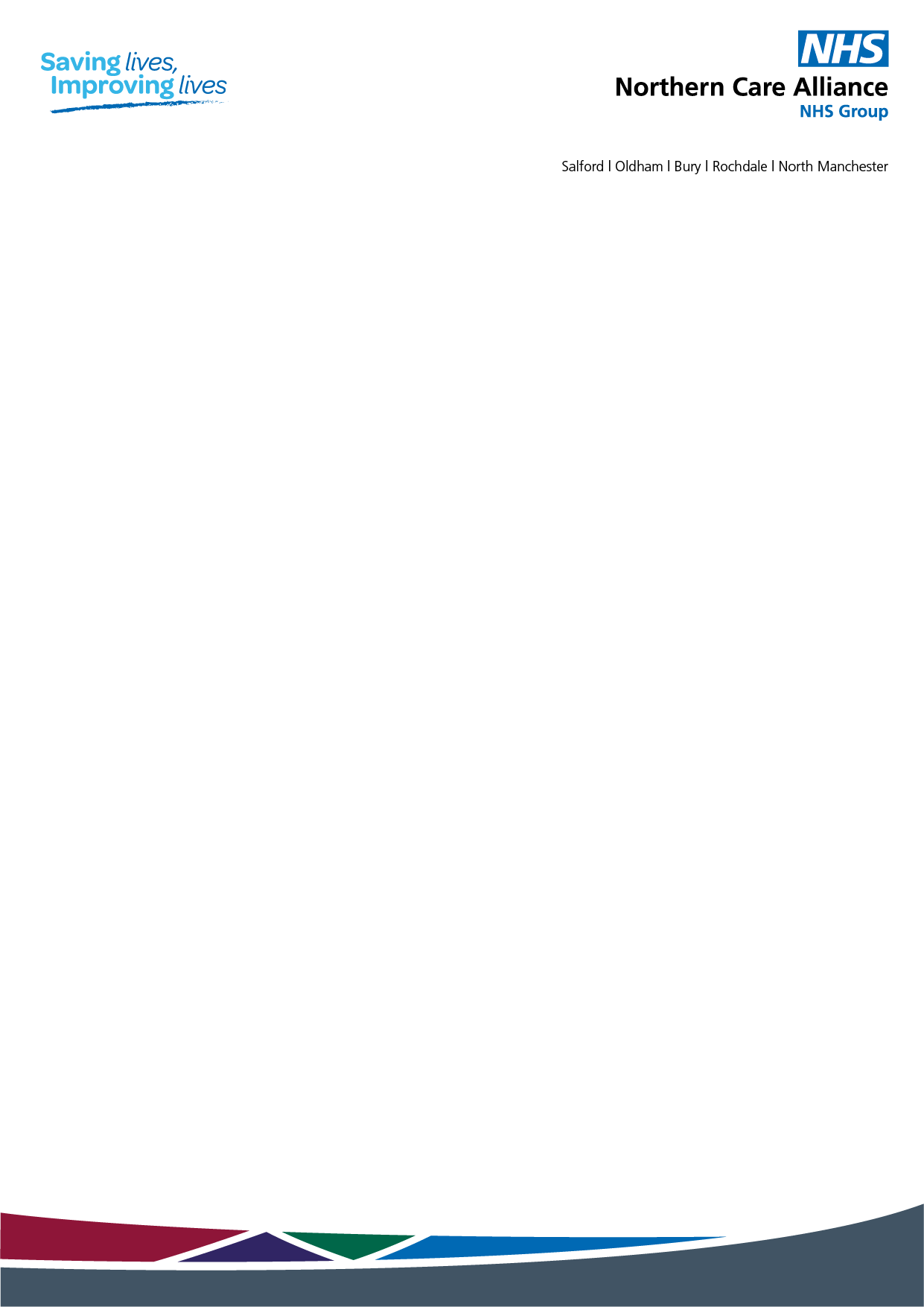
**Page 2**

**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.

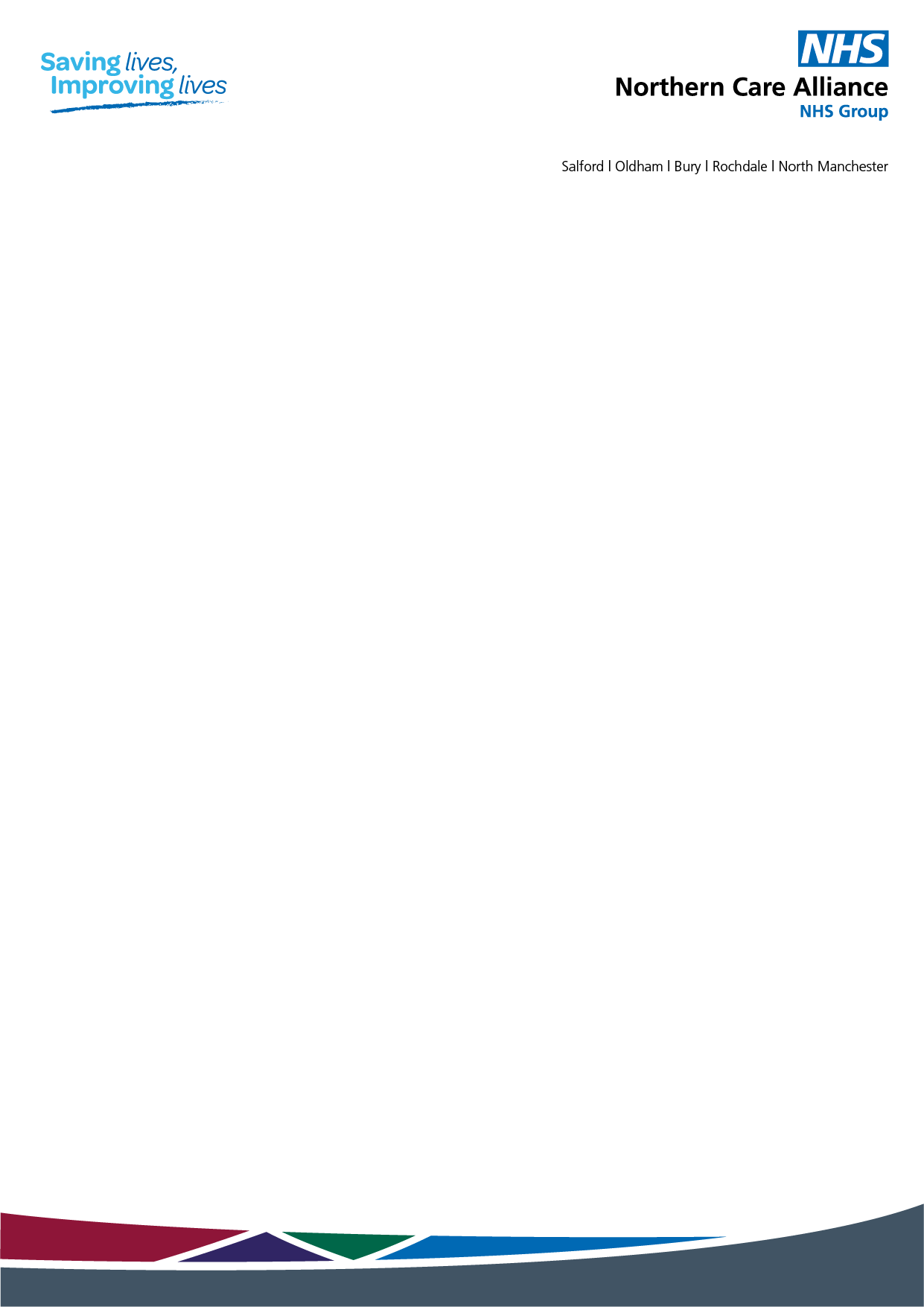
Page 2 needs to be completed by parent/carer of the child being referred.

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Parent/Carer Consent (we cannot accept a referral 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 | | 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: |  | | |



|  |  |  |
| --- | --- | --- |
| 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? | | |



**Page 2**

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

* To be completed by parents/carers

Age