

(SLT Admin Purposes Only)

Date received:

[Click here to enter a date.](#)

Chronological Age:

[Click here to enter text.](#)

Route:

[Choose an item.](#)**SPEECH AND LANGUAGE THERAPY****REQUEST FOR SPEECH, LANGUAGE AND COMMUNICATION
(SLC) SUPPORT
FOR CHILDREN NOT YET ATTENDING SCHOOL SETTINGS**Salford Care Organisation
Northern Care Alliance
NHS Foundation Trust

Patient Surname:	Click here to enter text.
Patient First Name:	Click here to enter text.
Date of Birth:	Click here to enter text.
Sex:	Click here to enter text.
NHS Number:	Click here to enter text.
Ethnicity:	Choose an item.
Religion:	Choose an item.
Address :	Click here to enter text.
Date of Request for Support:	Click here to enter a date.
Referred By: Name: Designation: Department: Other: Contact Address: Contact Number: Email Address: Team / Setting Email Address:	Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text.
GP:	Click here to enter text.
Next of Kin Name: Relationship to Patient: Home Telephone: Mobile Telephone: Other Telephone:	Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text. Click here to enter text.
Nursery Nursery: Other:	Choose an item. Click here to enter text.
Special Communication / Access Requirements: Do any reasonable adjustments need to be made for the family? Interpreter Required: Language: If other: Correspondence regarding this request to be copied to yourself?	(Please give specific requirements) Click here to enter text. Choose an item. Choose an item. Click here to enter text. Invite letter to book appointment? Choose an item. Appointment confirmation letter? Choose an item.
Do parents / carers feel that there is a problem in the child's home language?	Click here to enter text.

Other professionals involved: (provide name if known) Audiology: Date and result of recent hearing test: Consultant Paediatrician: Starting Life Well/Early Help Practitioner: ENT: Other:	Please provide relevant reports and/or assessments if applicable Choose an item. Click here to enter text. Click here to enter text. Choose an item. Click here to enter text. Choose an item. Click here to enter text. Choose an item. Click here to enter text.
Involvement from Social Services: If Yes, threshold of need: Looked After Child:	Choose an item. Choose an item. Choose an item. Click here to enter text.
Results: ASQ3 Communication (0-19 team): ASQ SE (0-19 and EHP):	Choose an item. Choose an item.
Most recent WellComm: (0-19; EHP; settings where in use) Non-health practitioners: please attach Well Comm Score sheet.	Choose an item.
What strategies/interventions, e.g. WellComm activities, have you used or advised on to develop the child's speech / language / communication skills? Please include a copy of the child's latest Play Plan / Intervention targets where applicable.	
Has this child previously had support from the Speech and Language Therapy Department? (If yes, please state what this was).	
What do you hope to gain from this request for support?	Choose an item.

PLEASE COMPLETE THE FOLLOWING SECTIONS (page 3) IF THE CHILD:

- SCORED BLACK ON ASQ
- RED ON WELLCOMM
- OR IF YOU HAVE ADDITIONAL INFORMATION THAT WOULD SUPPORT A REQUEST FOR AN ASSESSMENT BY A SPEECH AND LANGUAGE THERAPIST

Please refer to the age-related norms at speechandlanguage.org.uk/help-for-families/ages-and-stages and describe the child's difficulties in each area, providing as much detail as possible and including relevant examples.

<p><u>COMPREHENSION</u> Difficulties understanding what is said and following instructions. <i>If yes, please describe</i></p>	<p>Choose an item. Click here to enter text.</p>
<p><u>EXPRESSIVE LANGUAGE</u> Difficulties expressing him / herself using appropriate vocabulary and sentences <i>If yes, please describe</i></p>	<p>Choose an item. Click here to enter text.</p>
<p><u>SPEECH CLARITY</u> Difficulties using clear speech appropriate to age <i>If yes, please describe</i></p>	<p>Choose an item. Click here to enter text.</p>
<p><u>SOCIAL INTERACTION</u> Difficulties interacting appropriately with peers and adults verbally and non-verbally <i>If yes, please describe</i></p>	<p>Choose an item. Click here to enter text.</p>
<p><u>FLUENCY SPEECH / STAMMERING</u> Difficulty with speaking fluently without excessive pausing, repetition or stretching out sounds <i>If yes, please describe</i></p>	<p>Choose an item. Click here to enter text.</p>
<p><u>GENERAL DEVELOPMENT / OTHER</u> e.g. Childs Play Skills, behaviour, attention and listening skills</p>	<p>Click here to enter text.</p>

CHECKLIST

	Yes	N/A
Have all sections been completed?	<input type="checkbox"/>	<input type="checkbox"/>
Has verbal consent for the request for support been obtained from parent / carers?	<input type="checkbox"/>	<input type="checkbox"/>
Have you included copies of relevant reports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you included a copy of the EYFS tracker if applicable?	<input type="checkbox"/>	<input type="checkbox"/>
Have you included copies of all Play Plan targets where applicable?	<input type="checkbox"/>	<input type="checkbox"/>
Have you included a copy of the WellComm results/score sheet if applicable?	<input type="checkbox"/>	<input type="checkbox"/>

For admin use;

Decision: Accepted

Appointment type: EYs IA Talking Tots

**Triaged
Diagnosis**

**by:
Code:**

Date:

Decision: Declined

SLT: Email sent

Admin: Add to EPR

