|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Therapy Admin Only | Date Received |  | Triaged by: |  |
| Referral Priority |  | Pathway: |  |
| Initial Appointment |  | Date: |  |

**INTEGRATED CHILDRENS THERAPY TEAM REFERRAL FORM**

**Occupational Therapy Physiotherapy Speech and Language Therapy Dietetics**

**Additional forms MUST BE completed for the following:**

* **Occupational Therapy for Sensory Needs**
* **Speech and Language Therapy (SLT) Feeding and Swallowing**

**(For feeding & swallowing concerns, referrer does NOT need to complete additional SLT form)**

***All referrals must be completed by a healthcare professional unless referring to Speech & language therapy.***

|  |  |
| --- | --- |
| Child’s name:Address: | Date of Birth:Male/Female:Casenote No:NHS No:Telephone No: |
| School/Nursery:Name of Parent/Carer(s): Relationship to child: Who has parental responsibility? |
| Are there any Safeguarding concerns? Is the child subject to a looked after child review? YES NO  YES NOIf yes, please give further details (include social worker/family support worker details):**If circumstances change following this referral please let the relevant Therapy Team know** |
| GP details:Paediatrician: Other professionals involved: |
| * **Diagnosis/Reason for referral:** *Please attach recent clinic report if available*
* *Please explain impact of this problem on child/young person’s daily life, inc severity of symptoms:*
* *Relevant medical history (medication, weight, height where appropriate)*
 |
| Do you think there is a discrepancy between the child’s cognitive ability and their functional performance? YES NO N/A |
| Specific RequirementIs an interpreter or signer required? YES NO Service Required:Can parent’s/carers access written information YES NO |
| Other relevant information (include any previous contact with Therapy team): |
| Has the parent/carer/child/young person been informed and given their consent for this referral?YES: NO:Please make sure all parts of the form are completed.Decisions regarding the acceptance of referrals are based on information supplied. Incomplete forms will be sent back to the referrer for completion prior to the referral be processed by the team.  |
| Signed Referrer: | Designation: |
| PRINT Name: | Date: |
| Address: | Telephone Number: |

**ADDITIONAL INFORMATION TO BE COMPLETED FOR REQUESTS FOR SPEECH AND LANGUAGE THERAPY ASSESSMENT:**

|  |  |  |
| --- | --- | --- |
| Child’s Name: | Date of birth: | NHS number: |
| **Please indicate the difficulties the child is facing: *(Please complete with parents/guardians)******Please refer to the referral information document for information*****Using the table below please indicate if any of these are true for the child by ticking ✓ the relevant boxes.** ***Please take into account the child’s developmental level:***

|  |  |  |  |
| --- | --- | --- | --- |
| **SPEECH**  |  | **USING SPOKEN LANGUAGE** |  |
| Has limited consonant sounds when speaking |  | Uses only single words when more would be expected |  |
| Uses speech sounds that seem incorrect for age. Speech may sound immature or be unintelligible  |  | Uses limited two - three word phrases when longer phrases expected |  |
| Has a range of speech sounds, but these are not produced clearly, e.g. speech may be ‘slushy’. |  | Uses phrases but omits or uses incorrect grammatical elements e.g. plurals, verb tense endings, pronouns. Language sounds immature.  |  |
| Has difficulty making him/herself understood. |  | May have ‘muddled’ phrases, with unusual word order. |  |
| Becomes frustrated when trying to express him/herself using speech. |  | Becomes frustrated when he/she cannot get their message across.  |  |
| Has a croaky or husky voice |  | May have restricted vocabulary for age or use incorrect or unusual words |  |
| The child’s speech is dysfluent (possibly a stammer), e.g. may repeat sounds, words or part phrases |  | In the case of the child learning two or more languages; are there difficulties in the development of both/all? |  |
| Speech sounds ‘nasal’ and/or child overuses ‘m’ ‘n’ or ‘uh’ |  |  |  |
| **UNDERSTANDING SPOKEN LANGUAGE** |  | **COMMUNICATION AND INTERACTION** |  |
| Miscomprehends what is said, gets muddled, does not understand spoken language as expected (this is as regards verbal, not written language comprehension difficulties) |  | Has spoken language, but has difficulty conversing in the usually expected ways. |  |
| Needs additional clues e.g. pictures/gestures to follow instructions |  | Quality or quantity of interaction is affected, e.g. may prefer solitary activities |  |
| Acts on instructions only when sees peers already responding i.e. has to use information from environment to understand |  | Needs or uses alternative methods of communication to spoken language |  |
| Responds to part of an instruction, but not all. |  | May not use gesture or pointing to help get message across |  |
| Does not seem to be able to answer ‘why’ questions and/or is unable to reason and deduce information |  | Child appears fearful of speaking and/or communicating, particularly with adults.(see SLT information initially, regarding adaptive practice for this issue) |  |
| Is unable to comprehend less literal language and implied meaning (when 6+ years old) |  |  |  |

**Please ensure the child has had a recent hearing test and enclose the results.*** **Please describe any other difficulties not listed above:**
* **Please describe any coping strategies the child/family/school already have in place:**
* **Please describe how these difficulties are affecting the child’s daily life:**
 |
| Please make sure all parts of the form are completed. This form must be accompanied by the Integrated Children’s Therapy referral form.**Decisions regarding the acceptance of referrals are based on the information supplied.** |

**Please send completed referral forms to:** **yhs-tr.ChildrenTherapyAdmin@nhs.net**

Or see theChildren’s AHP Therapy Service Access Routes for York Selby, Scarborough Whitby, Ryedale Flow Chart for base addresses.