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

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| --- | --- | --- |
| Child’s Name: | Date of birth: | NHS number: |

|  |  |
| --- | --- |
| **What are the child’s main communication difficulties?** | **Please describe examples and include any relevant reports e.g. Educational Psychologist’s** |
| * Attention and Listening |  |
| * Understanding spoken sentences   and verbal instructions |  |
| * Expressive language (forming   sentences and grammar) |  |
| * Vocabulary knowledge and use |  |
| * Speech sounds/unclear speech |  |
| * Dysfluency (stammering) |  |
| * Social Communication   Including - interaction with others - play |  |
| * Verbal reasoning skills e.g. inference, prediction and problem solving |  |
| * Selective Mutism/can speak   happily at times, hardly or not at all  in other situations |  |

Clinic letter attached: yes/no

**Level of concern:**

Family - Low/High Referral Agent: - Low/High

Child/Young person: Low / High / Not applicable

Please describe any coping strategies the child/family/school already has in place.

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.**