York Teaching Hospital NHS
NHS Foundation Trust

Children's Therapy Team

Referral Pack

Contents:

York Teaching Hospitals NHS Foundation Trust is the NHS provider of children's Therapy services (Speech & Language Therapy, Occupational Therapy, Physiotherapy and Paediatric Dietetics) for children and young people, 0 – 18 years in York, Selby, Scarborough, Whitby and Ryedale.

This referral pack will provide information to referrers on how the Children's Therapy Service operates, the criteria and guidelines for referral, referral procedure and how to contact the service for further information and advice.

Context

Children have an important job to do. They need to grow, learn, socialise and play and do this every day by exploring the boundaries of their abilities. When they are successful, children develop and thrive.

Where children have learning, emotional, psychological or physical difficulties, this can affect their ability to grow, speak, learn, socialise and play, resulting in difficulties with basic day-to-day activities. This will affect their ability to learn, participate in school activities, make friends and be independent in adulthood.

The Children's Therapy Team works with children, young people and their families/carers to maximise their health, function and independence.

The therapy service aims to work with parents, health and education professionals in supporting the development of all children. We try to ensure that parents have access to information about how to support their child to develop, what to expect and whether to be concerned. We provide training and advice to parents, health care professionals and education to ensure that they have the knowledge and skills to provide rich opportunities for development. We provide resources, leaflets, therapy ideas and training to enable health and education staff to support children with mild to moderate difficulties wherever possible. As a result we expect that many children will be supported by those people who know the child best and spend time with the child on a daily basis.

There are, however, some children who either do not respond to this early intervention or who need more specialists support. These are the children who may need to see a qualified therapist who will be able to assess the child and identify their needs, discuss and agree with parents and health/ education professionals how best to meet those needs and evaluate response to intervention to inform further planned input. Our service helps to support children using a 3 tier approach:

Universal level:

- Staff in settings should understand the areas covered by therapists and have knowledge of how skills develop in these areas.
- This will create an understanding of children's needs and staff can identify areas of concern.
- Understanding a child's difficulties forms the basis for adaptive and supportive practice (see targeted).

- Therapy services will provide support for this tier through bespoke training for settings and access to our traded training offer – this can be found in the Therapy Section:http://www.yorkhospitals.nhs.uk/childrens_centre/your_childs_hospital_journey/therapy_services
- Advice and support will also be provided through liaison with therapists.

Targeted level:

- The communication and physical needs of some pupils will be met through knowledge of suitable adapted and enhanced practice.
- At this targeted level the children would benefit from good practice strategies for communication and physical skills and would not need regular or continued input from therapies.
- In addition, some children will require additional support for their communication skills/physical development that can be met by setting specific targeted interventions for language, communication, social needs/ physical and sensory development needs.
- This may be delivered through group work.
- In order for this to work, setting staff will implement targets during the school week in a focused way, following discussion with the therapists and modelling of target activities as required.

Specialist level:

- Children who currently have a high level of specific therapy need would receive specialist intervention from direct assessment, programme planning and input by a therapist. Some children may need support from Occupational Therapists, Physiotherapists, Speech and Language Therapists and Dieticians.
- This would be in addition to the understanding of the issue at a Universal level and the adaptive and/or enhanced provision received through the setting at a Targeted level.

The following guidelines explain which children may need this specialist support and how to access it.

Who should I refer?

Children and young people aged 0 – 18 years who have a York, Selby, Scarborough, Whitby or Ryedale GP or attend a school in these areas and their GP/consultant and/or parents would like the child's care to be provided by the York NHS trust therapists
In addition to above criteria:

- Children who present with a complex or uneven profile of development.
- Children whose needs cannot be met by those who work closely with them.

Dietetics:

Dietitians work with infants, children, young people and their parents/carers to diagnose and treat a wide range of dietary and nutritional problems.

Dietitians translate current research on food, health and disease into practical guidance to enable children, young people and their families to make appropriate choices.

It is vital that assessment and advice is provided by a suitably qualified person in order to safely support growth and development at this vulnerable time.

All dietitians are regulated by the Health & Care Professions Council (HCPC). They publish a register of dietitians and other health professionals who meet their standards. Only those on the Register can call themselves dietitians.

Dietetic therapy aims to optimise growth and development, improve/manage symptoms and achieve optimum nutrition.

Please refer to appendix 1 for more specific guidance.

Occupational Therapy:

Occupational Therapists (OTs) work with the child, parents and teachers to find solutions to minimise the difficulties children face, helping them to carry out the activities they need or want to do, in order to lead fulfilling lives.

Our OT Team will see children and young people with:

- Complex conditions, e.g. Duchenne Muscular Dystrophy
- Complex Neurology, e.g. Cerebral Palsy
- Perceptual-motor difficulties
- Motor planning difficulties /coordination difficulties
- Sensory processing difficulties affecting function
- Moderate – severe delays with fine motor skills and activities of daily living including:
    - Dressing
    - Eating
    - Pre-handwriting and handwriting skills
    - School activities
    - Self-care and independence
    - Difficulties with seating and positioning

Please refer to appendix 2 for more information.

Occupational Therapists provide intervention programmes, which may be carried out by non-professionals if taught how to do so. Therapy advice should always be incorporated within the daily routine of the child's life.

Children who present with primary emotional and behavioural difficulties not related to any underlying motor dysfunction should not be referred.

Physiotherapy

Physiotherapy aims to promote the health and wellbeing of children and young people. It aims to help maximise movement and function when someone is affected by injury, illness, developmental delay or other disability. A paediatric physiotherapist possesses a sound knowledge of childhood development, how patterns of movement develop from birth, and a wide range of clinical conditions.
This may include:

- Musculoskeletal conditions and musculoskeletal injuries specific to childhood
- Orthopaedic conditions, including pre and post-operative surgery
- Complex conditions, e.g. Duchenne Muscular Dystrophy
- Complex Neurology, e.g. Cerebral Palsy
- Moderate – severe delays with gross motor skills (e.g., sitting, crawling, standing, walking & running)
- Poor balance in sitting or standing
- Abnormal walking or movement pattern
- Co-ordination disorders
- Difficulties with mobility (e.g. moving around the floor, moving between sitting and standing, walking, running (dependent on the age of the child)

Please refer to Appendix 3 for more specific guidance.

Physiotherapists provide intervention programmes, which may be carried out by non-professionals if taught how to do so. Therapy advice should always be incorporated within the daily routine of their life.

Speech & Language Therapy

Speech and language therapy supports the development of children and young people who present with speech, language, communication and /or eating and drinking difficulties
This includes difficulties with:

- Understanding spoken language
- Using spoken language
- Developing speech sounds
- Social communication
- Speaking in school (child may be silent)
- Stammering
- Voice e.g. husky or hoarse (referral to ENT is required prior to referral)
- Eating and drinking (This refers to the process of eating, drinking and swallowing rather than in children choosing to eat a restricted diet).

Please refer to Appendix 4 for more specific guidance.

How do I refer a child or Young Person?

- The Children's Therapy Service will accept referrals from Health visitors, School Nursing, Paediatrician, and General Practitioners.

Referrals should be made on the Integrated Children's Therapy Service referral form to ensure that all the information required to process the referral is provided including the additional information forms are required.

All referrals should be sent to: **yhs-tr.ChildrenTherapyAdmin.nhs.net**
Or by post:
(Please see Children's AHP Therapy Service Access Routes for York Selby, Scarborough Whitby, Ryedale Flow Chart in the Quick reference section of this pack)

Or for further advice, please contact the Children's Therapy Team:

- York and Selby Occupational Therapy and Physiotherapy: 01904 726753
- York And Selby Speech and Language Therapy: 01904 726753
- Scarborough, Whitby and Ryedale Occupational Therapy and Physiotherapy: 01723 342357
- Scarborough, Whitby and Ryedale Speech and Language Therapy on 01723 342472

- **Additionally, Speech and Language Therapy accept referrals from school and pre-school settings,** e.g. Playgroups, child minders or Nurseries, using the integrated referral and additional SLT information forms.

- **Speech and language therapy also accept parental referrals:**
  For this, parents/carers need to complete:

1. **For children 5 years of age and under;**
   The 'Parent Speech and Language Parental Referral Form'

2. **For children and young people over 5;**
   The Integrated referral and additional information forms

Then send to:

For York and Selby Area:
Children's Therapy Team,
Child Development Centre,
York Teaching Hospital,
Wigginton Road,
York,
YO31 8HE.

If parents require help filling in this form please advise them to call: 01904 724366 (York and Selby)

For Scarborough Whitby, Ryedale Area:
SLT Dept,
Beck House,
3 West Parade Rd,
Scarborough,
YO12 5ED.

If parents require help filling in this form please advise them to call 01723 342472 (Scarborough, Whitby and Ryedale)

Urgent referrals can be taken over the telephone but the referral form will need to be completed to support this. Referrals may be made to one therapy service or all four therapy services on the same form by ticking the appropriate boxes and completing the additional forms as required.

The child's parents or guardian must consent to the referral.

What will happen next?

Once received the referral will be processed within five working days to:

- Check that all required information has been provided and parental / guardian consent obtained. If further information is required the referral will be put on hold pending receipt of further details.
- Determine the level of complexity of the referral and need for an integrated assessment.
- Allocate the referral to the appropriate therapist or team.
- Once processed, the parents / carers will be contacted to arrange an appointment for the child to be seen at the most appropriate location e.g. clinic, early years setting, school or home.
- The child will be prioritised according to need and we will aim for them to be seen within 18 weeks of acceptance of the referral.
- At the initial appointment the child and parents / carers will be seen by a qualified therapist who will ascertain from the parents/carers (and others where appropriate e.g. early years setting, school) the child's presenting difficulties and their own particular concerns.
- Undertake an initial assessment to identify the child's level of functioning.
- Agree with parents / carers an appropriate course of action.
- With the consent of parents / carers, communicate that course of action to the referrer and other interested parties e.g. health visitor, GP, early years setting, school, consultant.

What happens if the child does not attend the initial appointment?

All children who do not attend the initial appointment are managed under the 'Did not attend Protocol' which considers whether there are any safeguarding issues that should be raised. Parents / carers are contacted to ascertain the reason why the child was not brought to the appointment and to arrange another appointment. If there is no attendance at this point the child will be discharged back to the referrer for further action.

Appendix 1
Guidance on referring children to a Dietitian

Children with diabetes, metabolic disorders, cystic fibrosis, renal or liver disease, childhood cancers, and eating disorders should receive dietetic support as part of a specialist multidisciplinary team and should be referred to the appropriate specialist team/service rather than to an individual Dietitian. Children and young people will then see the dietitian who works in these teams.

Faltering growth

Many factors including medical conditions and social factors can contribute to inadequate nutritional intake and cause faltering growth. Dietetic assessment is appropriate for infants and children who have a downward deviation in weight across 2 centiles or who have a weight/height below the 0.4th centile.

Children with restricted dietary intake/selective eating

First line advice and support on eating problems should be sought from health visiting services.

Referral to a Dietitian is appropriate for those who are not growing well or who have significantly restricted intakes or are omitting whole food groups.

Children with autistic spectrum disorders

Sensory issues can affect food preferences and mealtime behaviours. A dietetic assessment is appropriate for those whose growth is restricted or who have significantly limited dietary range and there is concern that this could cause nutritional deficiencies.

Based on the assessment, advice can be offered on optimising nutritional intake within the scope of the individual's abilities and advice on supplementation where appropriate.

Nutritional deficiencies

If nutritional deficiencies such as iron deficiency are identified children can be referred for dietary assessment and advice.

Gastrointestinal problems

Reflux, constipation and diarrhoea can cause feeding and nutritional problems and also be contributed to by feeding practices or eating patterns. A dietetic assessment is appropriate when symptoms are causing concerns about growth or nutritional intake.

Based on the assessment, guidance can be offered on feed type and feeding patterns in infants and on adjustments to food and fluid intakes.

Neurological or Physical feeding difficulties

Children with structural abnormalities of the orofacial and upper digestive tract and those with neuro-disabilities such as cerebral palsy can present with eating and drinking difficulties. Referral to a Dietitian is appropriate when the eating and drinking difficulties cause nutritional concerns.

Guidance may be required on food fortification, texture modification, nutritional supplementation or tube feeding.

A multi professional approach is appropriate for complex cases. Joint dietetic and Speech and language clinics are available for infants and children who require oral motor assessment and nutritional assessment.

Weight management

BMI above the 91st centile suggest a child is overweight; a child above the 98th BMI Centile is very overweight.

Weight management services provided by council health improvement teams should be considered where available and appropriate.

Overweight or obese children can be referred if individualised dietetic assessment and advice is required or where other relevant medical conditions co-exist.

Food allergy

Nutritional adequacy can be compromised when food allergies require the exclusion of major food groups such as milk or wheat, or in cases of multiple foods allergies. Patients with known or possible food allergies can be referred to the Dietitian for assessment and advice.

In cases where there are multiple or severe allergies referral to a Specialist allergy service is recommended.

Lactose intolerance

Infant and children with hereditary or transient lactose intolerance can be referred to the Dietitian for advice on the implementation of a nutritionally balanced lactose free diet.

Coeliac disease

Children with a confirmed diagnosis of Coeliac Disease should be referred to a Dietitian for individualised advice on implementation of a gluten free diet. On-going dietetic review is recommended for children with coeliac disease.
Guidance may be required on food fortification, texture modification, nutritional supplementation or tube feeding.

Appendix 2
Guidance on referring children for Occupational Therapy

The emphasis of Occupational Therapy is on overcoming functional difficulties that occur in daily life and may present at home or in school.

Referral is indicated for children who have an uneven pattern of development with obvious deficits in the following functions:-

- Postural – motor function
    - Abnormal tone – E.g. Postural tone is too high and there is resistance to passive movements.
    - Postural tone is too low and child has difficulty controlling their body e.g. in sitting / standing effecting functional use of upper limbs (compared to milestones)
    - Arms / legs / body may adopt fixed postures or there is a limited range and poor control of movements.
    - Asymmetrical movement – e.g. Part of body is used less, may be poorly controlled or weaker.
    - Certain postures or movement patterns are frequently used.
    - Functional motor difficulty e.g. Child has difficulty with sitting, use of hands for play, poor functional grasp / manipulation compared to other milestones.
    - Their quality of movement may be affected e.g. tremor on approach reach, overshoots target
    - Unusual movement patterns
    - Diagnosis of Cerebral Palsy / Evolving Motor Disorder
    - Deterioration in functional ability

- Gross and fine motor skills
    - Including difficulties with: Bilateral coordination/Hand strength/Dexterity/Handwriting and scissor skills/Deterioration in skills/accessing the curriculum

- Activities of daily living
    - Dressing
    - Eating and drinking
    - Bathing
    - Using the WC

- Motor planning
    - Limitation of postures or sequences of movements
    - Self-organisation
    - Spatial awareness
    - Sequencing movements

- Visual perception
    - Visual motor integration impacting function

- Sensory processing affecting function
    - **If children are requiring sensory processing assessment the additional information referral form must also be completed before the referral can be accepted**

- Other
    - Oncology or other life limiting conditions where there is a need for equipment and/or therapy to improve quality of life
      Hospital discharges in liaison with Social Care OT's .

Appendix 3
Guidance on referring children for Physiotherapy

Neurological concerns

- All children with a new diagnosis of Cerebral Palsy, who have a motor impairment impacting on movement and function
- Babies/children presenting with any of the following:
    - Abnormal tone –
        - Increased muscle tone where there is resistance to passive movements. Arms / legs / body may adopt fixed postures or there is a limited range and poor control of movements.
        - Reduced muscle tone where the child has difficulty controlling their body and impacting upon the child's development
    - Asymmetrical or unusual movement patterns – part of body is used less, may be poorly controlled or weaker.
    - Functional motor difficulty e.g. child has difficulty with sitting, standing, walking or running compared to milestones. Their quality of movement may be affected e.g. child can walk but falls easily.
    - Acquired brain injury which has had an impact on child's motor skills – this may include altered tone, reduced coordination, muscle power and /or sensation.
    - Children moving into the area with a known neurological diagnosis and previous physiotherapy input.
    - Re-referral with **new/functional problems.**
    - Post-surgery rehabilitation.

Neuromuscular concerns

Neuromuscular conditions involving a progressive loss of functional motor skills. Physiotherapy can be very beneficial in terms of promoting independent skills, reducing deterioration and promoting health and well-being. Input is given depending on the child's needs at that time. Treatment and frequency will vary according to the age and stage of the child.

Children should be referred for physiotherapy if they present with the following:

- All children with a new diagnosis of neuromuscular disease.
- Concerns over lack of progress or deterioration in the baby / child's motor skill development where gross motor development appears to have stopped for more than 6 months.
- Loss of motor skills. Previously acquired skills are more effortful or show less coordination, e.g. tripping and falling.
- Re-referral with **new/functional problems / post-surgery.**
- Children with known diagnosis of neuromuscular disease and who have moved into the area.
- Children / young people presenting with an increase in respiratory difficulties.

Developmental concerns

Children, who have no neurological or genetic involvement and have normal patterns of movement, should be referred to physiotherapy **if** they are demonstrating a gross motor delay of 3-6 months or more (for children under 2 years) or delay of 9-12 months or more (for children aged 2- 5years). See guide below:

- Bottom shuffling is not an indication of abnormal movement patterns. Many children who bottom shuffle instead of crawling to move around the floor, start walking at a later age.
- Children presenting with specific syndromes and demonstrate gross motor delay as described above should be referred for physiotherapy.

Activity	Age child usually reaches milestone	When to refer to physiotherapy
Independent floor sitting	9 months	12 months
Independent rolling	6 months	12 months
Cruising	12 months	18 months
Independent walking	14 months (children who bottom shuffle are usually delayed in walking)	22 months
Jumping	3 years 2 feet together from bottom step	4 years
Climbing stairs	3 years – up and down holding hand rail, 2 feet per step	4 years
Riding tricycle	3 years – able to use pedals, steer round wide corners	4 years

NB: Activity leaflets to promote development can be found on the York Teaching Hospital children's website.

Idiopathic toe walkers

- Children who habitually walk on their toes should be referred for physiotherapy if they are over the age of 3 years
- Children under the age of 3 years should be referred to physiotherapy if there is asymmetry or if it is not possible to achieve 90° passively
- Altered postural tone – consider if toe walking is due to an underlying neurological condition, in which case refer to physiotherapy – these children may follow alternative pathway if the underlying cause has neurological origin

In toeing

Some children's feet turn in when they walk and this is very common in young children. It is one of the most common normal variants in children. Referral to physiotherapy is only needed if:

- Significant asymmetry is present
- Pain is present
- Child has tight hamstring muscles
- Child has metatarsus adductus (refer to orthotics for review first and onward referral ot physiotherapy if needed)
- Child is still in toeing after 6 years of age

Hypermobility

Joint hypermobility is defined as an excess in joint range of movement.

- Children should be referred to physiotherapy for hypermobility if they have:
- Delayed gross motor skills - if child is demonstrating a gross motor delay of 3-6months or more (for children under 2 years) or delay of 9-12 months or more (for children aged 2- 5years)
- Functional difficulties – e.g. unable to walk distances compared to norms.
- Pain

Musculoskeletal problems

- All children's musculoskeletal conditions and injuries should be referred to the Children's Therapy Team.
- Flat feet – **Do not refer** to physiotherapy as intervention is not needed. Refer to podiatry if the child has foot pain.
- Baby musculoskeletal problems. Babies presenting with talipies, torticollis, brachial plexus injury or plagiocephaly should be referred to physiotherapy

Juvenile Idiopathic Arthritis

Children who have difficulties which affect their function at home and / or school and require advice on the long term management of their condition should be referred to physiotherapy.

Chronic Fatigue Syndrome (CFS)

Physiotherapy and occupational therapy can offer advice on graded exercise, relaxation, pacing and home / school equipment.

Appendix 4
Guidance on referring children for Speech & Language Therapy

Please see the quick reference section of this pack for Summary Guidance for Speech and Language Therapy Referral.

Early communication skills

Appropriate referrals can be made to the Service if there are significant concerns regarding social interaction i.e. a child is disinterested in others and is not showing signs of attempting to communicate by pointing, making eye contact, using facial expressions or vocalising. Also, if there is no babble by 12 months old?

Language

Parents should be reassured that children vary greatly when learning language in the early years. There is a wide range of what is considered to be 'normal' in the preschool years. Typically, understanding of spoken language develops in advance of use of spoken language however delays can be present in one area or another or both. When considering a child's ability to understand spoken language it is important to consider contextual clues that we as adults often give (e.g. looking towards an object, pointing and whether the request is part of a daily routine).

Children in an education setting (pre-school/school) are usually able to benefit from the skills of the setting workforce who provide a communication friendly environment and encourage positive carer-child interaction. Schools and pre-schools have access to training packages from our service to support them in meeting the language and communication needs of their pupils throughout the school day. Children not yet in an education setting are able to access similar support through children's centres and toddler groups.
Appropriate referrals can be made to the service if there are significant concerns such as delayed and limited understanding of spoken language, no babbling/vocalisations/speech, and language difficulties which significantly impact on the child's ability to access the national curriculum.

English as an Additional Language (EAL)

In general, acquiring two languages within a bilingual family should not have any significant impact on a child's ability to develop communication skills. Typically developing children may show a mild delay in both languages initially, but demonstrate interest and enthusiasm for communication, catching up quickly and managing bilingualism without concern.
When English is not a first language, it is expected that there will be a 6-month delay in a child's understanding and use of English in comparison with their skills in their first language. Therefore, a child of chronological age 2 years 6 months, who has an English language age of 2 years, is considered to be age-appropriate.
A child who is age-appropriate in their first language, but more than 6 months delayed in English is not appropriate for referral as this is indicative of difficulties in learning a second language, rather than acquiring language in general. Most second/subsequent language learning children exhibit a 'silent period' This is an active stage of absorbing the new language and the child is usually 'testing out ' the new language within 6 months. A child that remains silent and looks to be losing confidence in communication in general, should alert concerns. Second/subsequent language learners are at risk of Selective mutism (see below.)

A pre-school child who is delayed in both/all languages is appropriate for referral to the Children's Therapy Service in order to determine the extent of delay, whether it is a disorder and to give appropriate advice,. This is via the drop in service.

Children who present with a delay in either language at school-age are not appropriate referrals, as Education staff should be able to support them from within their own resources. Schools should access support from the Specialist Teacher Advisory Service.

When making a referral for a bilingual child, please also consider factors that may be impacting on language development – for example, whether the child has had the opportunity to engage in interactive play with both adults and peers, and whether it is considered appropriate within their home environment to make eye-contact with adults. Also consider the length of time the child and parents have been in the UK, and the environments in which the child is exposed to English in comparison with their first language.
It is often worth encouraging families to attend local playgroups initially, particularly at Children's Centres where there are often play workers who can support the family in developing communication through their home language. Supporting play and communication development in the child's first language often results in a noticeable change to language skills. Make sure parents are not advised to only speak the new language. The child's language skills will develop most easily if the parents talk the language that comes most easily to them at home.

Speech

Speech sound development is a complex process and can take time. Sounds mature in a certain order and some are more difficult to say than others e.g. "f" is harder than "p". Children make many errors in these early years as they experiment and learn to talk. Most of these errors are a typical part of development until the age of around 3 years old with some errors naturally persisting until the age of 5 or 6. Children who have experienced a delay in developing language skills are likely to show a correlating delay in their use of sounds.

Average Speech and Language Development			
Sound	Age sounds are usually achieved by (90%)	Examples of sound in child's speech	Sound substitutions in developing speech
p, b, m, w	3yrs 5mths	Pop, baby, more, where	p may sound like b to begin with eg pee→bee
t, d, n	3yrs 5mths	Two, daddy, no	t may sound like d to begin with eg to → do
ng	3yrs 5mths	sing	Child may use /n/ eg sing → sin up to the age of 5
k/c, g	3yrs 5mths	Car, walk, go, bag	Child may use /t/ /d/ instead until 3;11 Eg car→tar bag →bad
h	3yrs 5mths	home	/h/ may be left off initiallyeg home → ome
f ,v	3yrs 5mths	fork, coffee, off van, river, move	child may use p,b,t or,d until 3;06 eg fork→bork
s, z	3yrs 5mths	Seesaw, bus, zebra nose	Child may use /t/or /d/ until 3;06+
y	3yrs 5mths	Yogurt, buying	
l	3yrs 11mths	Light, balloon	child may use 'w' or 'y' until 4yrs eg like→wike
Consonant blends eg sp, fl, st	3yrs 11 mths	Spider, flower, nest basket	Child will reduce the consonant blend of 2 sounds to 1 eg spider – pider or sider
sh, zh	4 yrs 11 mths	Sheep, wash measure	May use as /t/ or /d/ until 3;0 May use /s/ /z/after this until 5 yrs eg sheep→ seep
ch, j/dg	4yrs 11 mths	chip, watch jump, badge	May use as /t/ or /d/ until 4;0 May use as /ts//dz/ until 5 yrs eg watch→wats
Consonant blends of 3 consonants eg spl---	5yrs 11mths	split	Consonant blends of 2 or 3 sounds including r eg , bread, spring may not develop till age 6;5+

r	6 yrs 5 mths	rabbit, carry	Gliding: may present as /w/ or /y/ until 6;06 Eg rabbit→wabbit
th (θ) th (ð)	7yrs+	thumb there	May use b then f/v until 7yrs eg thumb→fum May use d until 4+ then v

Referrals are recommended:

- If there is a significant concern regarding physical or structural difficulties (e.g. hearing impairment, muscle weakness, cleft palate/nasality or coordination problems) or a child's speech is significantly unintelligible to the family refer before the age of 3 for assessment of speech sound development
- If at the age of 3 a child is still missing off beginnings of words and uses inconsistent vowels
- If at the age of 3.6 they are not using [p/b/t/d/n/m/k/g/f/v/s/z/] in single words or longer phrases
- If at 4yrs they are not using /l/ sh/
- If a child continues to use an interdental /s/ (lisping) or lateral /s/ after their adult front teeth have grown through (this is typically 6/7 years old)

Some children pick up strong regional variations (e.g. fumb for thumb) or have mild delays e.g. "w" for "r" i.e. "wed" for "red". These children can be supported within their everyday environment by parents and school staff and generally do not require SLT services.

Selective Mutism (SM)

SM is an Anxiety Disorder. It might better be explained as 'situational speech anxiety' and this commonly starts between the ages of 3 and 5. There can be late onset too however. A child with Selective Mutsim may speak happily and easily in one situation, but be very quiet, even silent, in others. Children with Selective Mutism may have speech, language or communication difficulties too, or they may not. Parents may see 'two different children'; the school one and the one that presents at home.

Some children with Selective Mutism speak, but only under duress or when the need is high enough, often leading to the (incorrect) idea that the child is being stubborn or controlling.

Children with Selective Mutism may soon start to fear other means of communication too, such as pointing or gesturing. They may also have a frozen expression and stiff body movements.

This disorder responds well to early intervention through adaptive 'Selective Mutism friendly' practice, especially in the Early Years, built on a basis of real understanding of the disorder. (Targeted and Universal levels- see SLT advice). Others with more entrenched or severe Selective Mutism may also need additional Specialist level input, led by the SLT, especially if they have not responded to a period of up to 4-6 weeks of Selective Mutism related Targeted level input.

Language Disorder

Some children have immature verbal language skills and these are relatively easy to identify; their language will sound young for their age e.g. "me go home" when the child is 6 years old.

Others may have a more unusual or disordered pattern of development. These children may appear more able in other respects, for instance with non-verbal problem solving, but then use muddled phrases, show unusual word order or struggle to 'find' the correct words.

Of these, some will be able to understand language relatively well, but not be able to express their ideas and others may have significant verbal comprehension deficits too. The comprehension difficulties may be masked however by the child's better problem solving skills, ability then to work things out and read situational cues.

These children may be frustrated by their inability to express their (more advanced) thoughts, or may try to fade into the background to mask their difficulties.

The term ‘Specific Language Disorder’ has been used in the past, to describe children with these better cognitive, than verbal skills. However, it is now known that these children may have other associated difficulties, such as with working memory.

Fluency (Stammering)

Stammering is an interruption in the smooth flow of speech and language. It can be very variable and affected by a wide range of factors e.g. emotions, the listener or the situation.

Children often experience a period of non-fluency whilst acquiring language. There are demands to remember, find new words and put them into phrases and short sentences. If you combine this with learning to co-ordinate lips and tongue movements it may mean that they stop-start, repeat and change the words they use. This can last a few weeks or even months until the child has mastered this new skill. They may also hesitate, get stuck or stretch out sounds which makes speech sound dysfluent (early stammering).
If this continues beyond those first months an early referral is recommended as it has been shown that dysfluency is more effectively treated in the pre-school years. Early referral is particularly recommended if there is a family history of stammering or if the child has other speech and language difficulties.

Referral is also recommended for a child /young person up to the age of 18 where the stammering has persisted, become a part of their communication and is causing an impact on their home and school lives. There may be some awareness, frustration and anxiety which could show in many ways. Some young people can also be very adept at hiding their stammer and avoid situations where they have to speak. It is recommended that they are also referred into the service. He/she are likely to be seen by a speech and language therapist who will support them and advise the family. Therapy will follow if necessary.

Feeding

Feeding assessment aims to determine whether the difficulties reported and observed have a structural (mechanical or neurological) cause. If a structural cause is identified, the child will be seen as part of the Therapy caseload for on-going assessment and management strategies until it is considered that the child’s needs are stabilised and can therefore continue to be managed by adults in their environment.
Indicators of structural feeding difficulties include:

- Failure to thrive, difficulty in developing a sucking action, coughing/choking, recurrent chest infections, physical difficulty in chewing more difficult textures, nasal escape or regurgitation.
- All children who are suspected to have difficulty in structural feeding should be referred to the Service for assessment.
- If you wish to refer a child for structural feeding difficulties completion of the additional feeding referral form is required.

Indicators of behavioural feeding difficulties include:

- Gagging on specific textures, rigidity surrounding times of eating, temperature of food, utensils used, and textures accepted within the context of the child otherwise following a normal developmental pattern.
- Children who have only behavioural feeding difficulties should not be referred. If they are they will be given advice and signposted to appropriate support from Health Visitors, School Nurses.

Communication and Interaction Difficulties - Autistic Spectrum Disorders

Autism is a lifelong, developmental disorder that affects how a person communicates with and relates to other people and how they experience the world around them. Children or young people with autism have differences in their skills in language and communication, social interaction and flexibility of thought.

One in a hundred people have an autistic spectrum disorder. The early identification and diagnosis of autistic spectrum disorders enables early autism specific interventions which improve outcomes for autistic children and their families.

Speech and Language Therapists work with children and young people with autistic spectrum disorders and their families and educational settings to support their language and communication skills, their interaction and learning.

Signs of communication and interaction difficulties indicative of autistic spectrum disorders in the early years may present as follows:

1. Spoken language:
    - The child doesn't use language, gestures or pointing to communicate.
    - The child has delayed language (for example less than ten words by the age of 2 years.)
    - Parents report a regression in or loss of use of speech.
    - Spoken language (if present) may include unusual:
        - Non-speech like vocalizations.
        - Odd or flat intonation.
        - Frequent repetition of set words and phrases ('echolalia'.)
        - Reference to self by name or 'you' or 'she/he' beyond 3 years.
    - Reduced and/or infrequent use of language for communication, for example use of single words although able to speak in sentences.

2. Responding to others:
    - Absent or delayed response to name being called, despite normal hearing
    - Reduced or absent response to social smiling.
    - Reduced or absent responsiveness to other people's facial expressions or feelings.
    - Unusually negative response to the requests of others (demand avoidant behavior.)
    - Rejection of cuddles initiated by parent or carer, although may initiate cuddles themselves.

3. Interacting with others:
    - Reduced or absent awareness of personal space, or unusually intolerant of people entering their personal space.
    - Reduced or absent social interest in others, including children of his/her own age – may reject others; if interested in others, may approach others inappropriately, seeming to be aggressive or disruptive.
    - Reduced or absent imitation of others' actions.
    - Reduced or absent initiation of social play with others, plays alone.
    - Reduced or absent enjoyment of situations that most children like, for example, birthday parties.
    - Reduced or absent sharing of enjoyment.

4. Eye contact, pointing and other gestures:
    - Reduced or absent use of gestures and facial expressions to communicate (although may place adult's hand on objects.)
    - Reduced and poorly integrated gestures, facial expressions, body orientation, eye contact (looking at people's eyes when speaking) and speech used in social communication.
    - Reduced or absent social use of eye contact, assuming adequate vision
    - Reduced or absent joint attention shown by lack of:
        - Gaze switching.
        - Following a point (looking where the other person points to – may look at hand.)

- Using pointing at or showing objects to share interest.

5. Ideas and imagination:
    - Reduced or absent imagination and variety of pretend play.

Signs of communication and interaction difficulties indicative of autistic spectrum disorders in primary school aged children may present as follows:

1. Spoken language
    - Spoken language may be unusual in several ways:
        - Very limited use .
        - Monotonous tone.
        - Repetitive speech, frequent use of stereotyped (learnt) phrases, content dominated by excessive information on topics of own interest.
        - Talking 'at' others rather than sharing a two-way conversation.
        - Responses to others can seem rude or inappropriate.

2. Responding to others
    - Reduced or absent response to other people's facial expression or feelings.
    - Reduced or delayed response to name being called, despite normal hearing.
    - A subtle difficulty in understanding other's intentions; may take things literally and misunderstand sarcasm or metaphor.
    - Unusually negative response to the requests of others (demand avoidant behaviour.)

3. Interacting with others
    - Reduced or absent awareness of personal space, or unusually intolerant of people entering their personal space.
    - Reduced or absent social interest in people, including children of his/her own age – may reject others; if interested in others, may approach others inappropriately, seeming to be aggressive or disruptive.
    - Reduced or absent greeting and farewell behaviours.
    - Reduced or absent awareness of socially expected behaviour.
    - Reduced or absent ability to share in the social play or ideas of others, plays alone.
    - Unable to adapt style of communication to social situations, for example may be overly formal or inappropriately familiar.
    - Reduced or absent enjoyment of situations that most children like.

4. Eye contact, pointing and other gestures
    - Reduced and poorly integrated gestures, facial expressions and body orientation, eye contact (looking at people's eyes when speaking) and speech used in social communication.
    - Reduced or absent social use of eye contact, assuming adequate vision
    - Reduced or absent joint attention shown by lack of:
        - Gaze switching .
        - Following a point (looking where the other person points to – may look at hand.)
        - Using pointing at or showing objects to share interest .
5. Ideas and imagination
    - Reduced or absent flexible imaginative play or creativity, although scenes seen on visual media (for example, television) may be re-enacted.
    - Makes comments without awareness of social niceties or hierarchies.

Signs of communication and interaction difficulties indicative of autistic spectrum disorders in secondary school aged children may present as follows:

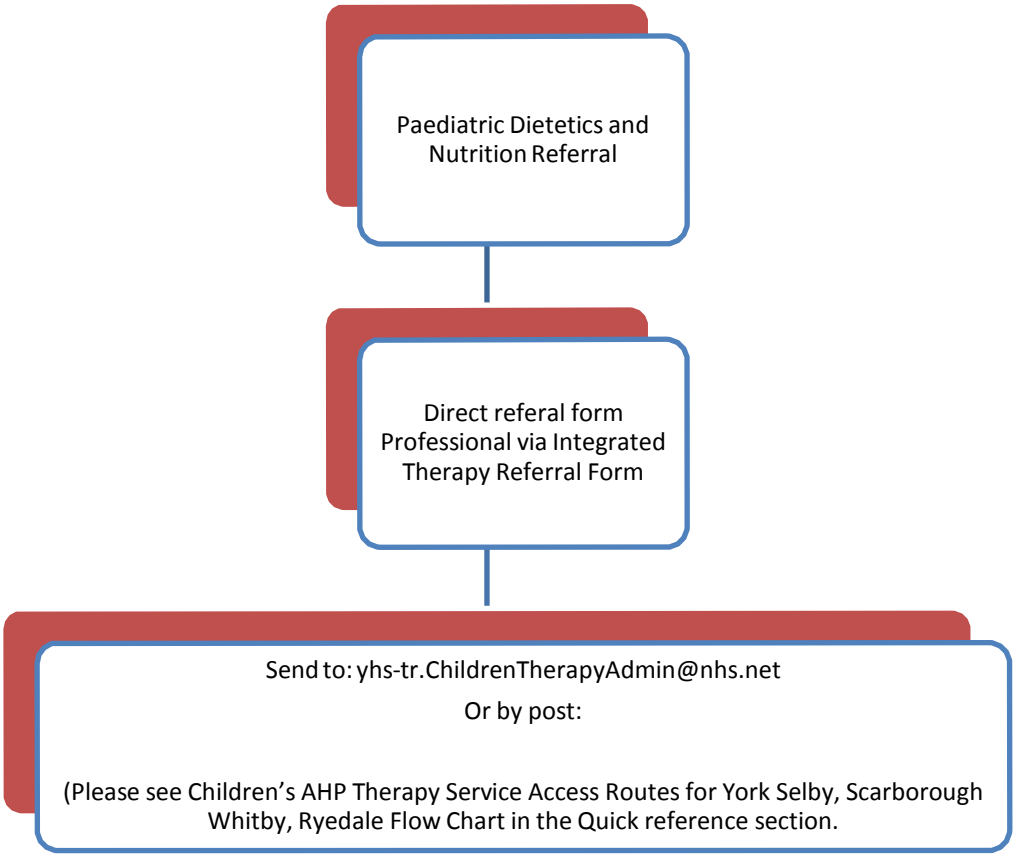
1. Spoken language
    - Spoken language may be unusual in several ways:
        - Very limited use.
        - Monotonous tone.
        - Repetitive speech, frequent use of stereotyped (learnt) phrases, content dominated by excessive information on topics of own interest.
        - Talking 'at' others rather than sharing a two-way conversation.
        - Responses to others can seem rude or inappropriate.

2. Interacting with others
    - Reduced or absent awareness of personal space, or unusually intolerant of people entering their personal space.
    - Long-standing difficulties in reciprocal social communication and interaction: few close friends or reciprocal relationships.
    - Reduced or absent understanding of friendship; often an unsuccessful desire to have friends (although may find it easier with adults or younger children.)
    - Social isolation and apparent preference for aloneness.
    - Reduced or absent greeting and farewell behaviours.
    - Lack of awareness and understanding of socially expected behaviour.
    - Problems losing at games, turn-taking and understanding 'changing the rules'.
    - May appear unaware or uninterested in what other young people his or her age are interested in.
    - Unable to adapt style of communication to social situations, for example may be overly formal or inappropriately familiar.
    - Subtle difficulties in understanding other's intentions; may take things literally and misunderstand sarcasm or metaphor.
    - Makes comments without awareness of social niceties or hierarchies.
    - Unusually negative response to the requests of others (demand avoidant behaviour.)

3. Eye contact, pointing and other gestures
    - Poorly integrated gestures, facial expressions, body orientation, eye contact (looking at people's eyes when speaking) assuming adequate vision, and spoken language used in social communication.
4. Ideas and imagination.
    - History of a lack of flexible social imaginative play and creativity, although scenes seen on visual media (for example, television) may be re-enacted.

(*Sources: NICE guidelines (August 2014), National Autistic Society)*

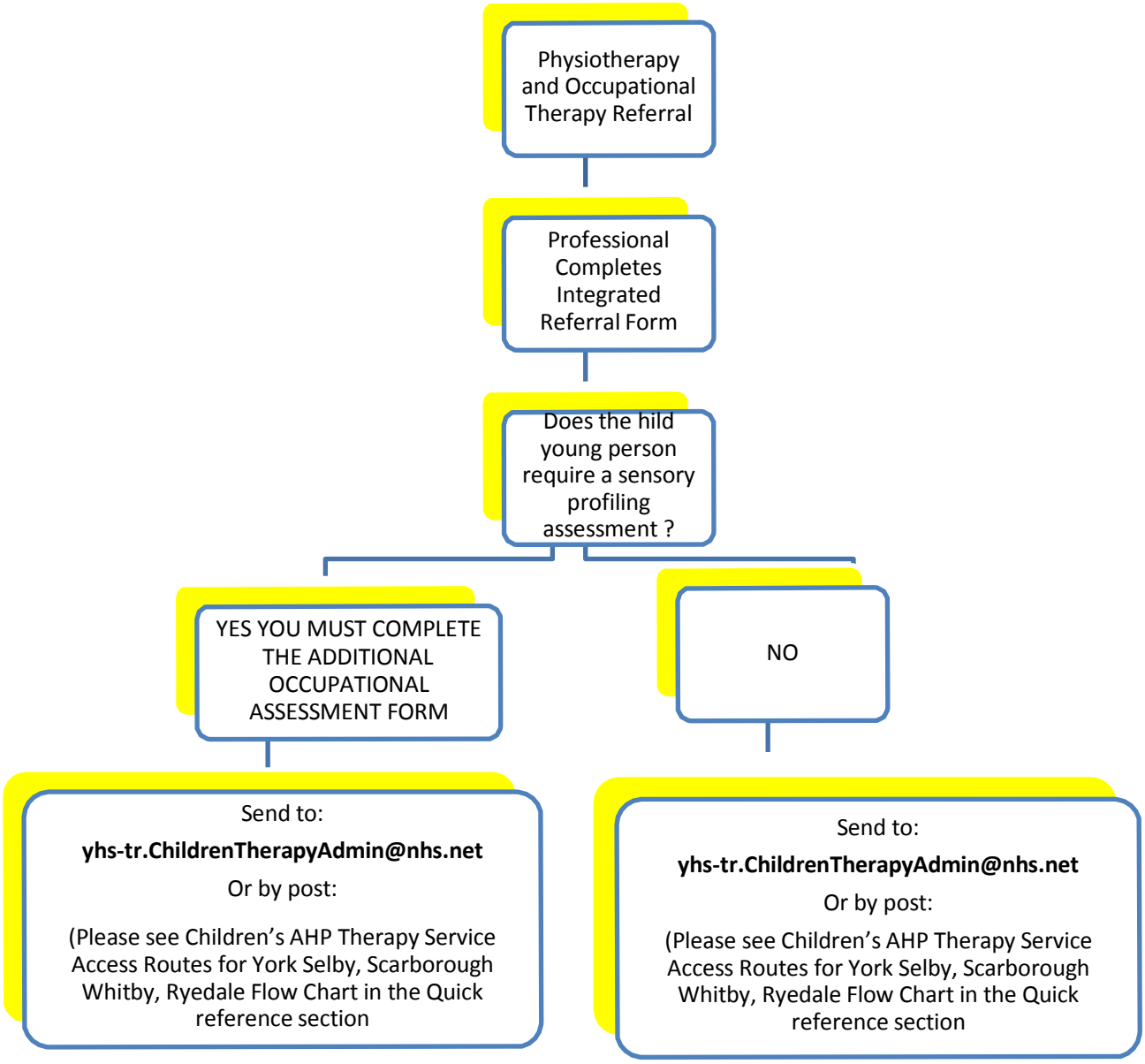
Quick reference: Referral guide to Children's Therapy Services: Paediatric Dietetics and Nutrition



Further information:

- For Scarborough, Whitby and Ryedale Dieticians Administrators call 01723 342415
- For York and Selby Dietician Administrators call 01904 725269

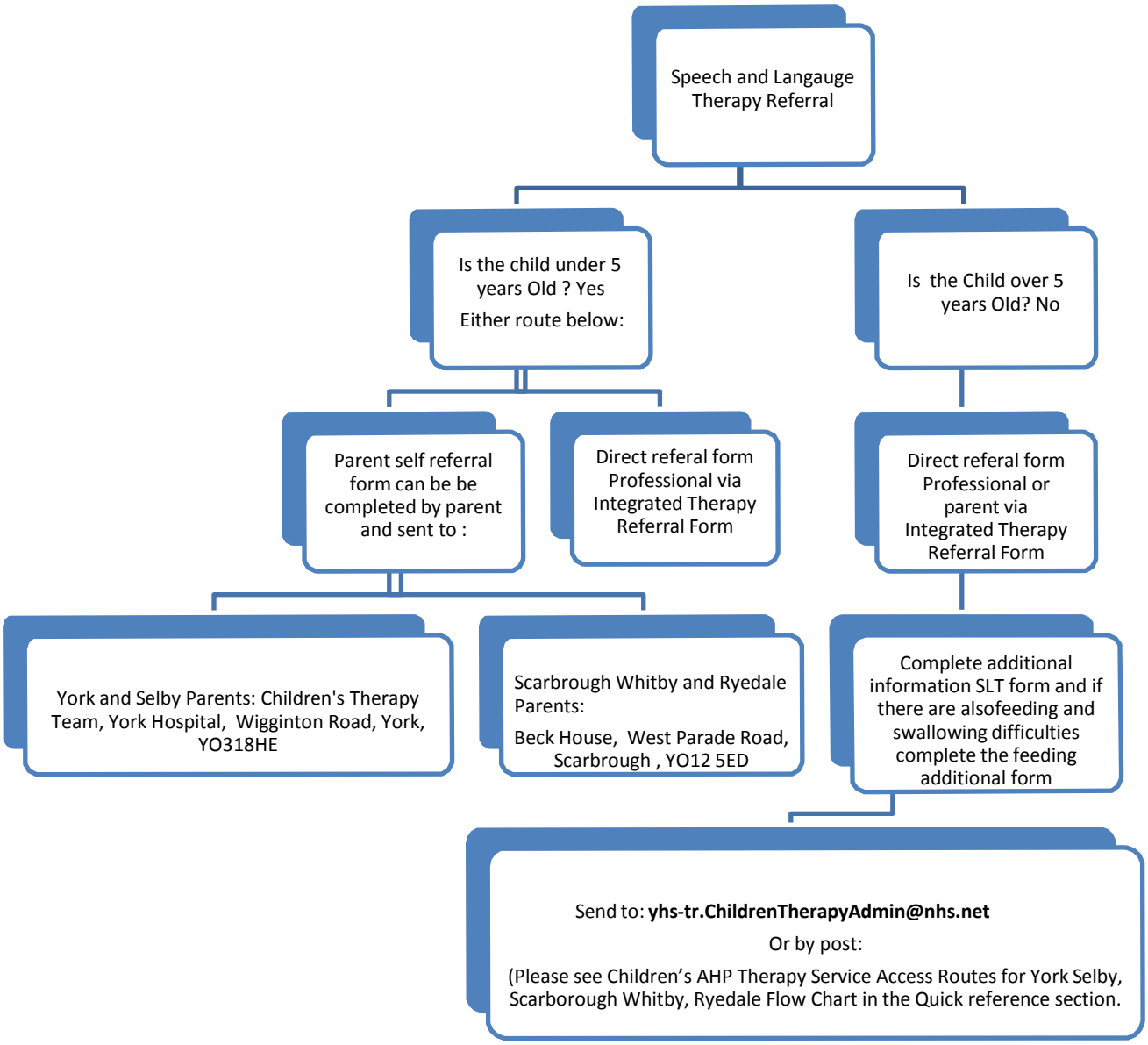
Quick reference: Referral guide to Children's Therapy Services: Physiotherapy and Occupational Therapy



Further information:

- For Scarborough, Whitby and Ryedale Occupational Therapy and Physiotherapy call 01723 342357
- For York and Selby Occupational Therapy and Physiotherapy call 01904 726753

Quick reference: Referral guide to Children's Therapy Services: Speech and Language



Further information:

- For Scarborough, Whitby and Ryedale Speech and Language Therapy call 01723 342472
- For York and Selby Speech and Language Therapy call 01904 724366

Quick reference: When to refer to Speech and Language and when to watch and wait

Refer at any age if the child has :

- unintelligible speech
- speech skills that seem significantly delayed (see the chart below)
- verbal comprehension and/or expressive language impairments that are noticeably outside the expected range and affecting access to the curriculum
- a stammer
- lost communication abilities
- 'nasal' sounding speech and/or over uses 'm', 'n' or 'uh' sounds
- a croaky or husky voice not attributable to a cold
- a very varied speaking profile (parent/carer reports child talks easily at home but is silent in the EY or school setting)

By 18 months

• A vocabulary of first words is emerging (around 50 words or more) • Child understands what others say in familiar situations • Understands more words and phrases than they can say • Child copies words and possibly some short familiar phrases e.g. "what that?" • Parents understand the child's speech more than unfamiliar listeners • Words may be made of small range of sounds, often used in babbling e.g. b, d and m (and vowels). • Words are short e.g. "beh" for 'bread'	• Child has a few words (10-20) • Possibly using jargon or nonsense language for the main part • Looks with interest when hears language but no attempts to copy words • Only understands very familiar words in known situations e.g. "You want juice?" • Looks with interest when hears language but no attempts to copy words • Words are not used for a few communication functions	• Poor attention e.g. unable to sit with adult for short period • Does not make eye contact or show interest in adults or other children • Not saying any words • Not using words for communication (e.g. may just say words for no apparent reason) • Doesn't look to people or objects when named • Does not seem to understand what is said much at all. • Doesn't turn to look where sounds are coming from (hearing?) • Has lost social or language skills
DO NOT refer	**Do not refer. Review at 23 months (if not improved then refer to Speech and Language therapy)** **See SLT advice sheet;** 'Advice for Early Years-delayed language' sheets	**Refer to Speech and Language Therapy** **Also see advice sheet/s;** 'Gesture'

BY 2 YEARS

• Vocabulary increasing, possibly hard to list all words said. • Still mostly single words, but some 2 word phrases may be	• 20-50 single words • Some simple pretend play. • Able to concentrate for short spells • Possibly jargon	• Little pretend play • Poor attention and/or can't share attention e.g. looking at a book with an adult • 0-20 single words

heard. • Speech intelligible to close family • Understands some words out of context • Can understand some short phrases without clues • Child using language in more ways e.g. not just to ask for things or comment	(nonsense speech) used with one or two words interspersed • Responds to familiar instructions and language only	• No apparent comprehension skills • Or, can only understand stressed single words in familiar contexts • Not responding to their name • Has lost speech or language skills • Not sharing attention by pointing to or following point to things of interest • Attempts at words are unintelligible • Words used repetitively e.g. just to name items • Speech sounds 'nasal' and child may use 'uh', 'm' and 'n' a great deal
DO NOT refer	**Monitor in home/setting** **See SLT advice sheet;** 'Advice for Early years-delayed language'	**Refer to Speech and Language Therapy** **Also see advice sheet/s;** **'**Gesture'
	BY 2½ YEARS	
• Using some two word phrases e.g. "Daddy shoe" • Understands some questions e.g. "What?" ('is it' and 'doing') • Understands basic instructions when clues are absent e.g. "Put the bear on the chair" • Short 'telegrammatic' phrases used • Still most intelligible to family and others familiar with the child. • Child can keep on a subject for a little while	• Has an <u>increasing</u> vocabulary of single words, but no signs yet of linking these. • Comprehension of language seems good, but there are concerns regarding number of single words used expressively	• Poor comprehension of language • Few or no words used although other skills appear better (e.g. play, attention and problem solving) • Vocabulary is not increasing or when new words are added others are lost. • Loss of language skills previously there. • Memorised speech used rather than 1 to 2 word level phrases 'made up' by the child • The child 'echoes' what is said a great deal • Speech unintelligible to most, even close family • If the child is stammering • Child has varied speaking profile e.g. uses words to 'chat' at home, but is silent in early years setting • Speech sounds 'nasal' and child may use 'uh', 'm' and 'n' a great deal

DO NOT Refer	Monitor in home/setting **See SLT advice sheets** 'Advice for Early years- delayed language'	Refer to Speech and Language Therapy **Also see advice sheet/s;** 'Dysfluency in the Early Years' 'Situational fear of talking' 'Gesture'
By 3 YEARS		
• Producing two to three word phrases, e.g. "me want juice" • Understands basic position words such as 'on', 'in' and 'under' • Welcomes and responds to adult suggestions most of the time • Child using language to accompany play • Some speech can be difficult to understand, but child is mostly intelligible	• Little sign of/only a few words linked, but child appears to have better development in other areas e.g. play or attention • Not understanding more than basic 'what' questions e.g. "where?" • Frequently unintelligible to other people than close family	• Poor comprehension of language • Only saying single words, (or learnt phrases) although other skills are good • Limited pretend play • Cannot attend for longer than a few minutes • Child is stammering • Child has varied speaking profile e.g. uses words to 'chat' at home, but is silent in early years setting • Language used repetitively • Speech very unintelligible
DO NOT Refer	**Monitor in home/setting** **See SLT advice sheets;** 'Advice for Early years- delayed language' 'Children who have unclear speech- speech delay'	**Refer to Speech and Language Therapy** **Also see advice sheet/s;** 'Dysfluency in the Early Years' 'Situational fear of talking' 'Gesture
By 4 YEARS		
• Utterances are developing to be at least 5-6 words long and used appropriately • Child is developing knowledge of concepts of size and shape • Child is intelligible to most people • In speech, 'fricative' sounds, f v s z are used but may be missed in blends e.g. 'pider' (spider) • The child may still have difficulty with sh, zh, ch and j sounds • The sounds t and d can be used for k and g (e.g. tar for car), up until around 3 ½ years	• Child finding it difficult to understand questions • Child has short phrases of up to 4 words • Child's phrases are developing but sound 'young' for the child's age • Child's speech sounds 'young' (may be accompanied by immature language development). • Child's social skills seem immature and in line with general developmental level	• Noticeable difficulties with comprehension of language • No evidence of 5-6 word utterances (although other skills good) • Odd phrases; words seem muddled • Unintelligible even to family most of the time. • Shows an unusual speech pattern, e.g. omits all initial consonants, vowel abnormalities, over use of one consonant sound or mixes up sounds in words • Child uses odd or 'sing-song' intonation pattern

• 'l' may only be developing by the end of this time frame too • Child developing ability to reason and report outside the 'here and now' about e.g. past events		• Child has heightened vocabulary in area of interest but poor vocabulary in other areas • Child is not using language for basic conversation • Child uses language repetitively • Child uses odd or 'sing-song' intonation pattern • Child is stammering • Child has varied speaking profile e.g. uses words to 'chat' at home, but is silent in early years/school setting • Child has significantly gruff or husky voice that does not change over time (gain referral to ENT prior to referral)
DO NOT Refer	**Monitor in home/setting** **See SLT advice sheets;** 'Language comprehension', 'Expressive language' 'Children who have unclear speech- speech delay' 'social communication skills for pre-school children'	**Refer to Speech and Language Therapy** **Also see advice sheet/s;** 'Dysfluency in the Early Years' 'Situational fear of talking and Selective Mutism'
BY 5 YEARS		
• Utterances are long and appropriate but some grammatical features may still be incorrect • Child links phrases with 'and' and later, 'because' • Child may still have difficulty with sh zh ch j but these should have developed by the end of this age range • Blends with 3 consonants will continue to be difficult for the child e.g. "splash" • Child may have a lisp or slushy speech • Child still uses ''w' or a similar sound for 'r' • Child uses 'f' or 'th' or	• Child has intelligible but has immature sounding speech; sounds like a younger child • Child may have immature expressive language and does not understand as well as others of his/her age, but this seems part of the child's general level of development • Child may find more complex position words difficult to understand e.g. 'behind' • Child has immature social skills and this appears to relate to the child's	• Severely unintelligible even in context. • Significant comprehension and /or expressive language difficulties • Child seems to understand very well, but has marked difficulties with expressive skills • Difficulties understanding instructions containing several key words or understanding question words, e.g., who/where/when/why • Child is mixing pronouns e.g. 'he' for 'she' or 'you' when s/he means 'me' • Child is not interacting

<table>
<tr><td>‘v’ for voiced (noisy) ‘th’</td><td>developmental level</td><td>with peers
• Child may talk repetitively and not be developing the usual two-way conversational abilities
• Child is stammering
• Child has varied speaking profile e.g. uses words to ‘chat’ at home, but is silent in early years/school setting
• Child has significantly gruff or husky voice that does not change over time (gain referral to ENT prior to referral)</td></tr>
<tr><td>DO NOT Refer</td><td>Monitor in home/setting

See SLT advice sheets;
‘Language comprehension’,
‘Expressive language’
‘Children who have unclear speech- speech delay’
‘Social communication Skills for Primary School Aged Children</td><td>Refer to Speech and Language Therapy

Also see advice sheet/s;
‘Dysfluency- school age’
‘Selective Mutism’
‘Speech disorder’
‘Articulation disorder’</td></tr>
<tr><td colspan="3">BY 6-7 YEARS</td></tr>
<tr><td colspan="2">• Child is known to have developmental delay and speech and language are characteristic of the child’s developmental age/level.
• The child’s speech, language or communication need can be targeted through strategies, interventions and supportive practice within school e.g.
➢ For immaturities in the child’s speech and language that need the usual reminders e.g. ‘felled’ for ‘fell or ‘catched’ for ‘caught’
➢ For immature speech patterns
For immature social skills, social comprehension and inferential skills (when this is in line with the child’s developmental level)

• For difficulties with 3 consonant blends or difficulties with ‘r’ or ‘th’ before the ages detailed below
• For Literacy difficulties e.g. reading comprehension</td><td>• Child has continued difficulties with producing intelligible speech or seems to be stuck in a ‘young’ speech pattern e.g. still uses ‘t’ for ‘k’ and ‘d’ for ‘g’ (see chart below)
• Child unable to pronounce ‘r’ and ‘th’ by age 6½ to 7
• Child has unusual speech, may sound ‘slushy’ or ‘lispy’ (air escapes down side of tongue or tongue slips out e.g. for ‘s’)
• Child has nasal sounding speech
• Child’s speech is unintelligible and/or children monitored by school at 4½-5 years who have not improved
• There are significant comprehension and/or expressive language difficulties affecting access to the curriculum and the SLT’s assessment will be helpful (please state if you feel the child’s skills in other areas are more advanced than in verbal language areas)
• Child finds it very difficult to get his/her message across, possibly struggling to think of the words needed
• Child does not have friendships or relate to peers as might be expected
• May find it hard to make social judgments in communicative situations</td></tr>
</table>

	• Child may mis-read non literal language and implied meaning (can't 'read between the lines') • Child is stammering • Child is silent or mostly silent in school, when parents/carers report a very different child at home • Child has gruff or husky voice not attributable to a cold
DO NOT refer or seek further information from SLTSee SLT advice sheets; 'Speech delay' 'Language comprehension' 'Expressive language' 'Social communication, pre-school, school age and secondary school age' 'Higher level language difficulties' 'Word finding and vocabulary'	**Refer to Speech and Language Therapy** **Also see advice sheets;** 'Speech disorder' 'Articulation disorder' 'Dysfluency- school age' 'Selective Mutism'

References:

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- Miller J (1981) Assessing Language production in children. Milestones document.
- Boston et al (1981) Clinical management of articulatory.
- National Autism Plan for Children (NAPC) Produced by NIASA
- National Initiative for Autism: Screening and Assessment, Published by the National Autistic Society March 2003.
- Pre-school SLT referral protocol, Charlotte Firth, March 2015
- Phonological chart – Dodd, B., HOLM, A., ZHU HUA and CROSBIE, S., (2003), Phonological development: a normative study of British English-speaking children. Clinical Linguistics and Phonetics, 2003, VOL. 17, NO. 8, 617–643

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Quick reference: Referral guide: Speech and Language Therapy Parent /self-referral

Parental self-referral can be made to Speech and Language therapy through the Parent Speech and Language Parent Referral Form. The form be downloaded from the website http://www.yorkhospitals.nhs.uk/childrens/referrals or provided by the GP, Paediatrician, setting or local Children's Centre. Please note that this route is only accepted for referrals to Speech and Language Therapy for Children who are under 5 years old. Parents must complete the form, sign and send to:

For York and Selby Area: **Children's Therapy Team,** **Child Development Centre,** **York Teaching Hospital NHS Foundation Trust,** **Wigginton Road,** **York,** **YO318HE.**	**For Scarborough, Whitby, Ryedale Area:** **SLT Dept,** **Beck House,** **3 West Parade Rd,** **Scarborough,** **YO12 5ED.**
If parents require help filling in this form please advise them to call: **01904 724366 (York and Selby)**	**If parents require help filling in this form please advise them to call** **01723 342472 (Scarborough, Whitby and Ryedale)**

York Teaching Hospital NHS
NHS Foundation Trust

From 1st June 2016 Referral Access Routes Childrens Therapy Teams York Teaching Hospitals NHS Foundation Trust

Acceptable Referral source:
GP
Paediatrician
Other Healthcare Professional
Social Care colleagues
Education (SLT only)

Parental /self-referral is only accepted for children under 5 for referrals to speech and language

Scarborough/ Whitby Ryedale Therapy -	**Complete referral form and email to: yhs-tr.ChildrenTherapyAdmin@nhs.net Or send completed form to: Children's Therapy Department, Scarborough General Hospital, Woodlands Drive, Scarborough, YO12 6QL**	**OT/PT office no: 01723 342357**
York Scarborough Whitby Ryedale Paediatric Dietetics	**Complete referral form and email to yhs-tr.ChildrenTherapyAdmin@nhs.net Or send to: Dietetics Department York Teaching Hospital NHS Foundation Trust, Wigginton Road, York, YO318HE.**	**Office No York: 01904 725269 Office no Scarborough 01723 342415**
Scarborough/ Whitby Ryedale Speech and Language Therapy	**Complete referral form and email to: yhs-tr.ChildrenTherapyAdmin@nhs.net Or send to: Beck House, 3 West Parade Road, Scarborough, YO125ED.**	**SLT office no: 01723 342472**
York Selby Speech and Language Therapy	**Complete referral form and email to yhs-tr.ChildrenTherapyAdmin@nhs.net Or send to Children's Therapy Team, Child Development Centre York Teaching Hospital NHS Foundation Trust, Wigginton Road, York, YO318HE.**	**SLT office No: 01904 724366**
York and Selby Physio /OT	**Complete referral form and email to yhs-tr.ChildrenTherapyAdmin@nhs.net Or send to: Children's Therapy Team, Child Development Centre York Teaching Hospital NHS Foundation Trust, Wigginton Road, York, YO318HE.**	**Therapy Office No: 01904 726753**
Under 5's parental / self-referral SLT only	**Completed parental referral send form to: Scarborough Whitby Ryedale parents send to: Beck House, 3 West Parade Road, Scarborough, YO125ED**	**York SLT office 01904 724366 Scarborough Office 01723 34247**