**Parent Speech and Language Parent Referral Form**

**(For children under 5 years of age only)**

In order for us to assess your child’s needs, we need you to complete all the fields on this form. Forms that are not filled in fully will be returned to you for more information. If your child is 5 years old or older you need to get your GP, paediatrician or class teacher to refer your child for an assessment.

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| **For York and Selby Area:**  **Children’s Therapy Team,**  **Child Development Centre,**  **York Teaching Hospital,**  **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 )** |

Name

DOB

Address

NHS number (if known)

Phone number

GP

Health visitor

Nursery/child minder/ playgroup child attends

Parents’ name/s

Who has parental responsibility?

Any other professionals or agencies involved including social care?

What is your main concern about your child’s speech, language or communication skills?

Has she/he child had a recent hearing test? Yes No

Do you know the results?

Has your child attended a Small Talk group? Yes No

How many sessions if so?

Does your child seem to understand what you say?

Can your child put words together when speaking or does she/he say words one at a time?

Are you concerned that your child’s speech is unclear?

Does your child try to communicate, even if she/he finds it difficult?

The things you are concerned about; do they affect everyday life for him/her or the family?

Are you concerned about your child’s skills in any other areas (e.g. his/her physical abilities?)

**Form completed by: Print name:**

**Signature:**

**Relationship to child:**

**Date form completed:**

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| --- |
| **Office Use Only: Date referral received:** |

Date form checked:

|  |
| --- |
| Incomplete form - date sent back to parent |