**Children’s Integrated Speech and Language Therapy Service for Hackney and the City** Speech and Language Therapy, Room 31 – D Block, St Leonard’s Hospital, Nuttall Street, N1 5LZ

Tel: 020-7683-4262 Email: [huh-tr.SLTinfo@nhs.net](mailto:huh-tr.SLTinfo@nhs.net) Website [www.gethackneytalking.co.uk](http://www.gethackneytalking.co.uk)

**Children’s Speech and Language Therapy Referral Form**

|  |  |
| --- | --- |
| **Child or young person’s details** | |
| Name Click here to enter text. | DOB Click here to enter text. |
| NHS number Click here to enter text. | Gender Choose an item. |
| Address  Click here to enter text. | Name of nursery/School/College Click here to enter text.  full time  part time |
| Parent 1 Name Click here to enter text.  Parent 1 Phone number Click here to enter text.  Parent 1 Email Click here to enter text.  address as above? If not provide here:  Click here to enter text. | Parent 2 Name Click here to enter text.  Parent 2 Phone number Click here to enter text.  Parent 2 Email Click here to enter text.  address as above? If not provide here:  Click here to enter text. |
| Interpreter required? Choose an item.  Language spoken Click here to enter text. | Is the child or young person a City or Hackney looked after child?  yes no |

|  |  |  |
| --- | --- | --- |
| **Communication** | Tick any that apply | Please give details of your concerns:  (referrals with no/limited information will not be accepted) |
| Difficulty understanding |  |  |
| Difficulty using words and sentences |  |
| Difficulty with social skills |  |
| Play |  |
| Clarity of speech |  |
| Stammering |  |
| Voice Quality e.g. hoarse or croaky |  |
|  | |  |
| **Eating, drinking and Swallowing** | Tick any that apply | Please give details of your concerns:  (referrals with no/limited information will not be accepted) |
| * Child has signs of difficulty when eating/drinking e.g. Coughing / gagging / watery eyes |  |
| * Child has repeated chest infections |  |
| * Faltering growth/failure to thrive |  |
| * Oro-motor difficulties impacting on chewing/manipulating food in the mouth |  |
| * Does the child/young person need food/drink textures to be altered in order to swallow safely? |  |
| * Any difficulties sucking e.g. breast/bottle feeding? |  |

**Has the parent/carer consented to this referral?** Yes  No

**Please indicate which days the parent can attend:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Monday | Tuesday | Wednesday | Thursday | Friday |

|  |  |
| --- | --- |
| Referrer’s name | Telephone Number |
| Profession | Address |
| Date form completed: | |

**Once completed please hand to your School Link SLT or**

**if child not yet in school, then return to** [**huh-tr.SLTinfo@nhs.net**](mailto:huh-tr.SLTinfo@nhs.net)