

**Bury Paediatric Speech and Language Therapy**

**Request for Assessment – EARLY YEARS**

**PLEASE NOTE: ALL BOXES ON THIS FORM MUST BE FULLY COMPLETED FOR THE REQUEST FOR ASSESSMENT TO BE PROCESSED. ANY INCOMPLETE FORMS WILL BE RETURNED TO THE REQUESTER.**

**If you have any questions about completing this referral form, please call or email us before sending the referral and we will be in touch –** **burypaediatricslt@nca.nhs.uk** **01617242092**

**Child/Young Person’s details**

|  |  |
| --- | --- |
| Name:  | Date of birth:  |
| Gender:  | NHS number:  |
| Address:  | GP:  |
| Parent/Guardian 1: Please provide name/address/contact numberParental responsibility? Yes /No | Parent/Guardian 2: Please provide name/address/contact numberParental responsibility? Yes / No |
| Parents email address:  |
| Languages spoken at home:  | Interpreter required? Yes /No |

**Safeguarding**

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| Please tick if the child is subject to any of the following?* Child Protection Plan
* EHFS Plan (Early Help Family Support Plan)
* CIN action plan (Child In Need)
* TAF action plan (Team Around the Family)
 |
| If ‘**yes**’ to the above, please provide name and contact details of key person: |
| Is this a **Looked After Child?** Yes / No If **No,** please skip to the Health section and continue  |
| Person with parental responsibility |  |
| Consent for referral given by |  |
| Social Worker details: Name, address, contact number & placing authority required |  |
| Legal Status |  |
| Foster Carer / Carer name, address & contact number |  |
| Who can attend appointments? |  |
| Restrictions: Regarding information sharing during appointments and in reports / report circulation |  |

**Health**

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| --- | --- | --- |
| Has hearing been checked?  | Date(s);  | Result:  |
| Has vision been checked? *An eye test is not required for the referral to be made* | Date(s) (if known) | Result (if known): |
| Please list any other professionals involved and provide names and contact information if known: |

**Education**

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| Name, address & telephone number of Early Years setting (if appropriate): |
| Days / sessions attended: |
| Please give details of the current level of support: e.g. SEN support / EHCP: |

**Reasons for this request for assessment:**

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| Are there concerns about communication and language? Yes/No (if yes, please detail)**If yes, Nurseries/ Preschools must also complete the ‘WellComm Information Form’ (see p.5)****Tell us what you are concerned about and why** |
| Are there concerns about pronunciation of speech sounds? Yes/No (if yes, please detail)**If yes, and the child is using 2-3 words together, Nurseries/ Preschools must also complete and attach the Speech Sound Screen:** <https://theburydirectory.co.uk/speech-sound-screen-toolkit>  |
| Are there concerns about fluency/ stammering? □ NO□ YES – please describe  |
| Are there any other concerns about the child’s physical, medical and / or development?□ NO□ YES – please describe |

Impact of communication difficulties:

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| How do the child’s difficulties affect their ability to carry out activities they want to e.g., supermarket trips, trips to the park, playing with friends?  |
| How does the child communicate their basic needs? E.g. how do they request their favourite toy, food and drink, how do they let you know they want you to do something, or that they don’t like something?  |
| What is the child’s emotional response as a direct consequence of their communication difficulty e.g., tantrums, avoiding speaking etc?  |

**Nurseries and Preschools: WellComm Information**

**Please note: if it has not been possible to complete a WellComm assessment, please obtain parent consent to contact the service on 01617242092 or** **burypaediatricslt@nca.nhs.uk** **to discuss making the referral with the triage team.**

**A WellComm assessment can be completed across several sittings. If the child is finding it difficult to engage, consider assessing at a different time or starting from an earlier section.**

**Has a WellComm assessment been completed?**

□ NO – please complete the WellComm before referring and follow the referral instructions below.

□ YES – please provide the details below for all sections carried out

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Child Age at Time of Screen (Years and months)** | **Section**  | **Score:** **(Red/ Amber/ Green)** |
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| **If the child scores:*** **Amber** or a **single red,** please complete relevant sections of the Big Book of Ideas and review in 3 months’ time (please detail in next section).
* **Red** for their age section and **red** for the age section below, consider a referral to Speech and Language Therapy and complete relevant sections of the Big Book of Ideas and review in 3 months’ time.
 |

**Has a 3-month WellComm review been completed?**

□ NO – complete the review if indicated above

□ YES – please provide the details below for all sections carried out

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Child Age at Time of Screen (Years and months)**  | **Section**  | **Score:** **(Red/ Amber/ Green)** |
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| **At the 3-month review, if the child scores:*** **Red** for their age section or below – consider a referral to Speech and Language Therapy and continue to put into place targeted support.
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**If families haven’t received universal / targeted service input, this should be put into place prior to requesting a SALT assessment referral.**

**Please detail targeted interventions that have been implemented and the progress made:**

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| --- | --- | --- |
| **Targeted Intervention** | **Dates / Duration / Details** | **How has this made things better?** |
| **Family Hub / Children’s Centre sessions:**See Early Years Padlet for session information <https://padlet.com/BuryEarlyYears/bury-universal-universal-plus-family-offer-0-5-years-ea7fsql0nk8ynfjb> |  |  |
| **Can Do Programme** |  |  |
| **WELLCOMM (Big Book of Ideas)** input sessions/ advice |  |  |
| **Bury Paediatric SALT workshops** that setting staff have accessed – what you have implemented from your learning |  |  |
| **Published programmes:** e.g. Black Sheep Press packs Time To Talk Other (please state) |  |  |
| **Bury Paediatric SALT speech sound screening toolkit resources**<https://theburydirectory.co.uk/speech-sound-screen-toolkit> |  |  |
| **Any other strategies you have implemented** e.g from Quality First Teaching, Ordinarily Available Inclusive Practice, Bury Graduated Approach. This does not need to be a named programme, just describe what you have done, e.g. used a visual timetable, modelled single words, chunked instructions into smaller ones |  |  |
| **Other (please state)** |  |  |

**Requester details:**

|  |  |
| --- | --- |
| Name:  | Address and contact number: |
| Job Title:  |
| Would you like a copy of the appointment letter? |
| If appropriate, we will offer supported intervention that would need to be delivered by a member of staff in the child’s nursery/ preschool. Please provide a named contact for this: |
| I confirm that I have discussed this request for assessment with the parent / guardian and that they have given their express consent to this request for assessment. I am aware / have explained to the parent/guardian that this request for assessment is subject to triage and that the child may be signposted to another agency better able to meet the child’s needs, or further information may be requested before the referral to the service is accepted. | **Requester Signature** | **Date** |

**Parental Consent**

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| --- |
| **Parent/Carer Consent (we cannot accept a referral without this)** |
| I consent to this request for a Speech and Language Therapy assessment | **YES** | **NO** |
| I consent to my child being assessed by a student Speech and Language Therapist (with supervision) | **YES** | **NO** |
| I consent to relevant information to be shared with other professionals in order for my child to receive the best support | **YES** | **NO** |
| I confirm my email address is correct and consent to receiving emails | **YES** | **NO** |
| I confirm my mobile number is correct and consent to receiving text messages | **YES** | **NO** |
| **My child’s name is** |
| **My name is** |
| **My signature** |
| **Date:** |

**Please send completed form to:**

**Single Point of Access team (SALT Referral), Tel: 0300 323 3316 Textile Hall Email:** **SPOA.fax@nca.nhs.uk** **Manchester Road Bury BL9 0DG**