Please return to Speech and Language Therapy Service, Les Marais Centre, Le Grand Bouet, St Peter Port, GY1 2SB. **Please PRINT**

SPEECH AND LANGUAGE THERAPY REFERRAL FORM (School Age)

Surname	Mother's surname
Forename	Mother's forename
dob sex	Father's surname
Address	Father's forename
	Mother's tel (h) (w)
	Father's tel (h) (w)
School	Classteacher
GP	Practice

Family information: Siblings? YES/ NO How many?

Has any family member received SLT input? YES/NO

Hearing: referred for assessment YES NO

Other agencies involved – please specify e.g. social work, educational psychology, CASS etc

Relevant History – Has an additional need been identified? If so, please explain e.g. Down syndrome, autism, dyslexia

Has this child been referred to the SLT service before? YES/ NO

Is English the first language for this child? YES/ NO
What other languages are being used within the household?

Progress at School – Curriculum levels

Areas of concern

Understanding of Language ☐ Speech sounds ☐ Stammer ☐ Voice ☐ Talking ☐

Who identified these concerns?

Description of problem:

What has been tried in school to help?

Parent/ Carer View

Are parents/carers concerned YES / NO

Will parents/carers be able to access services? YES / NO

If not, please give details:-

IT IS ESSENTIAL TO OBTAIN PARENTAL PERMISSION BEFORE REFERRAL IS MADE

Referred by (please print) **Designation**		
Address		
Telephone	Signed	Date

I agree to this referral for assessment and am aware that parental support is essential for effective intervention

Parental consent received YES		NO		Parent's signature
(staff use only) **RECEIVED**				

PLEASE COMPLETE IN FULL – INCOMPLETE FORMS WILL CAUSE DELAY

PLEASE attach any reports that may help us to assess this child

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