The Royal Wolverhampton NHS Trust

CHILDREN'S SPEECH AND LANGUAGE THERAPY REFERRAL FORM

Please refer to the SLT Referral Toolkit when completing this form

ALL SECTIONS MUST BE COMPLETED

CHILD'S NAME	FAMILY NAMES		FIRST NAMES
	CHILD'S DOB	MALE/FEMALE	NHS NO.
CHILD'S ADDRESS			
CHILD'S SCHOOL/ SETTING			
PARENT / CARER NAME/S			
TELEPHONE NUMBER	HOME		WORK
GP	HV		School Nurse
ETHNIC GROUP	LANGUAGES SPOKEN AT HOME		INTERPRETER REQUIRED – Which language?
Referral form completed by			Role
Address			Telephone number
Why are you referring this child? What are your main concerns?			
Is the child's development age appropriate (please consider all aspects)	Yes / No Please comment		
Please comment on the following:			
Hearing	Date of last Hearing Test		Outcome
Listening and Attention			
Understanding of language			
Expressive language			
Speech sounds			
Fluency/Stammering			

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CHILD'S NAME

Social use of language & interaction	
Voice	
Feeding and Swallowing (If this is a significant area of concern, please use additional Feeding and Swallowing Referral form)	
What have you already put in place to support the CYP	
What support do parents/carers need to access the service?	e.g. are there any difficulties with literacy?

Are there any other agencies are involved? e.g. Social Services, SNEYS, Educational Psychology etc.

Agency	Named person	Contact Details

This referral has been shared with me and I consent to referral to the Speech and language Therapy Department.
I understand that appointment information and findings will be shared with the referrer.

Parent/Carer with parental responsibility	
Signed	
Name	
Date	

Please return this form to Speech and Language Therapy, The Gem Centre, Neachells Lane, Wednesfield, Wolverhampton, WV11 3PG Telephone 01902 01902 444363 or email to rwh-tr.speech-And-Language@nhs.net

Office use only		
Accepted	Rejected	Office Action