**Paediatric speech and language therapy**

**referral form guidance - voice**

**Please complete this form if you have concerns about a child’s voice.**

If you have concerns about a child’s fluency, communication or eating and drinking please use an alternative form available on the website here: <https://www.bdct.nhs.uk/how-to-refer-a-child/>

**Before completing this form, please refer to the referral criteria for voice available here** <https://www.bdct.nhs.uk/how-to-refer-a-child/> **to help you decide if a referral to speech and language therapy is appropriate.**

**Please ensure all relevant parts of the referral form are completed, if not, your referral may be rejected.**

**Prioritisation**

Our service prioritises referrals based on:

**Need** – including level of functional impact, risk factors for persistent difficulties, level of parental concern.

**Risk** – including significant social, emotional, and mental health concerns, safe-guarding concerns

**Timing** – including transition, education and health care plans.

**Team around the child** – including level of support required at home and within setting

**Paediatric speech and language therapy**

**referral form - voice**

**Information governance**

This form **may be** forwarded to speech & language by email to:

Fax-HPK.Admin-Hub@bdct.nhs.uk

but must be appropriately secured as it contains confidential /sensitive information.

Alternatively, fax 01274 215660

**Please note that we require parent/ carer consent for the referral & sharing of relevant information to have been discussed and obtained prior to completion of this form. we are unable to see children without this.**

1. **Consent for Referral to Speech and Language Therapy**

|  |  |  |
| --- | --- | --- |
| **Please tick to confirm if you have discussed and gained consent for the following with parent/carer** | **YES** | **NO** |
| **Referral to the Speech and Language Therapy Service** **(including, if appropriate, to assessment, treatment, and school visits):** |  |  |
| **Sharing of records with other health & education professionals:** |  |  |
| **Receiving SMS text appointments:** |  |  |

Please confirm that you, as the person with parental responsibility, consent to the referral to speech and language therapy for your child. Please also confirm you consent to the sharing of information with health and education professionals. You can find out more about how we collect, store, and share information at the following:

<https://www.bdct.nhs.uk/service-users-carers/your-health-records-data-protection/>

<https://www.bdct.nhs.uk/wp-content/uploads/2018/05/B-SLT-pdf.pdf>

**Parent / Carer Signature:** ……………………………….……………………

**Date:**  ………………………………

1. **Parent / Family Details**

|  |  |
| --- | --- |
| **Parent name/s:** |  |
| **Parent’s main language:** |  |
| **Does the parent require an interpreter?** | YES / NO | **Preferred gender of interpreter:** | Male / Female / Either |
| **Family history of speech & language difficulties (please state diagnosis):** |  |

1. **Child’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Forename:** |  | **Surname****(family name):** |  |
| **Known as:** |  | **Gender:** |  |
| **Date of birth:** |  | **NHS number (if known):** |  |
| **Address:** |  |
| **Postcode:** |  | **Telephone No:** |  |
| **GP practice /****GP name:** |  | **Mobile No:** |  |
| **Religion:** |  | **Ethnic origin** |  |
| **Child’s main language:** |  | **Child’s other language/s:** |  |
| **Nursery:** |   | **Health Visitor:** |   |
| **Medical diagnosis:** |  |
| **Other professionals involved e.g., paediatrician, audiology:** |  |
| **Is the child under Speech and Language Therapy for any reason other than a voice issue?** |  |

1. **Safeguarding and Risk**

|  |
| --- |
| **Please state any relevant information relating to safeguarding and/or risk:** |
|  |

1. **Timing**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **Is the child about to transition from one environment to another?****(e.g., nursery to primary e.g., primary to secondary)** |  |  |

1. **Referral Information**

To access voice therapy the child must have had a relevant ENT assessment in the past 6 months.

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **Has the child been assessed by ENT in the last 6 months?** **If yes, please provide details below.**  |  |  |
|  |  |  |
| **Has the child received previous input from Speech & Language Therapy for a voice issue?** **If yes, provide details below** |  |  |
|  |  |
| **Does the previous advice remain appropriate?** **If no, provide details of why not below** |  |  |
|  |  |
| **Please describe the child’s voice problem**  |
|  |

1. **Referrer’s Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer name:**  |  | **Referrer address:** |  |
| **Referrer role:** |  | **Referrer phone number:** |  |

**Referrer’s Signature:** ……………………………….……………………

**Date:** ………………………………

**PLEASE RETURN COMPLETED FORM TO:**

Fax-HPK.Admin-Hub@bdct.nhs.uk

Fax: 01274 215660