Derbyshire Community Health Services NHS
NHS Trust

Speech & Language Therapy Department

REFERRAL FOR ADVICE FROM SPEECH AND LANGUAGE THERAPY FOR DYSFLUENCY/STAMMERING

All sections of this form must be completed otherwise the referral form will be returned to you and the child will not be registered for an assessment at this time.

Return completed form to SLT Central Registration, Ilkeston Hospital. DE7 8LN

Child's Details (please print)				
Child's name	**First***	**Surname***		
	* **Male** ☐ **Female** ☐			
DOB*		**NHS Number**		
Address	*			
			Postcode*	
Telephone number	**Daytime***	**Mobile number**	**Email address**	
Home language(s)	*	***Interpreter required? Yes** ☐ **No** ☐		
GP name and address	*			
			Post Code	

Referral Details			
Reason for referral	**Please give a brief description of your concerns.** On a scale of 1-4 (where 4 =extremely worried), how worried are you about your child's talking?: *		
Assessment Venue	**All appointments will be offered in a clinic unless stated otherwise:**		
Referred by (please print name)	*	**Designation**	*
Address	*		
		Post Code	
Contact Number	*		

Chief Executive Tracy Allen

Chair Prem Singh

Education Setting	Name	Address and Contact number
Playgroup/Nursery/ School	*	* Days attending: am☐ pm☐ Not attending a setting ☐ Name of SENCo:
Are there any Health and Safety issues at this house? * If yes please provide details or a contact number:		Yes ☐ No ☐

Consent statements (parents please read the statements below carefully and tick yes or no to each as appropriate)	
Answerphone Messages: I consent to the Speech and Language Therapy Service leaving messages on my answerphone/voicemail, mentioning 'speech and language therapy'. No other personal information would be contained in the message. I understand that if these messages were overheard by people other than myself, this could result in my child's confidentiality being breached.	Yes ☐ No ☐
Short-notice appointments in school: if my child needs follow-up appointments in school/nursery, I consent to the speech and language therapist seeing my child at short-notice, without my express consent at the time (i.e. if the speech and language therapist is unable to contact me before the appointment), if slots become available due to cancellations etc..	Yes ☐ No ☐
Email correspondence: I consent to the speech and language therapist contacting me by email, to communicate patient-identifiable information about my child. I understand that my email account could be compromised and that this could result in my child's confidentiality being breached.	Yes ☐ No ☐
Electronic patient record. I consent to information about my child held on the Speech and Language Therapy electronic patient record being seen by other health services who are providing care to my child.**	Yes ☐ No ☐
Electronic patient record I consent to the Speech and Language Therapy Service seeing information held about my child on the electronic patient record of other health services providing care to me/my child.**	Yes ☐ No ☐

****NB:** 'A patients guide - Your electronic patient record and the sharing of information' is available to view or download at www.speech.derbys.nhs.uk

Signature of person with parental responsibility *……………………………

Parent/Legal Guardian's name (please print) * …………………………..

Date *…………………

Please send this form to

SPEECH AND LANGUAGE THERAPY REGISTRATION (CHILDREN)

Central Registration

Speech and Language Therapy Service

Ilkeston Community Hospital

Heanor Road

Ilkeston

Derbyshire

DE7 8LN

Telephone: 0115 951 2433

Fax: 0115 951 2434

We endeavour to see all initial assessments within 13 weeks of receiving the referral

For information about speech and language difficulties you may like to visit our website www.speech.derbys.nhs.uk.