PRE-SCHOOL AGED CHILD SPEECH AND LANGUAGE THERAPY REFERRAL FORM South Lee

This form is to be used to refer pre-school children to the HSE SLT Service

*Please complete **ALL** sections in full. Incomplete forms will be returned*

*Signed consent **must** be obtained from the child's parent(s)/guardian(s)*

Section 1: Personal Details

Child's name: _____

Gender: Male ☐ Female ☐

Date of Birth: _____

Home Address: _____

_____

Parent(s)/Guardian(s) Name: _____

Telephone Number(s): _____

G.P. Name: _____

Child's First Language: _____

Is this child multilingual? Yes ☐ No ☐ If yes please answer the following questions:

How long has this child had exposure to English? (for example since preschool entry)

_____

_____

Child's Medical History/Diagnosis: _____

_____

Section 2: Referral Details

Please state why you are referring this child to Speech & Language Therapy:

_____

_____

_____

_____

Section 3: Pre-school Details

Name of Preschool: _____

Pre-school Address: _____

_____

Pre-school Telephone Number: _____

Preschool Leader's Name: _____

Number of days the child attends preschool per week: _____

Section 4: Previous/Current Inputs

Has this child ever attended/has been referred to any of the following (***please tick all that apply***):

Paediatrician ☐ Audiologist ☐ ENT ☐ Speech & language Therapy ☐

Psychologist ☐ Area Medical Officer ☐ Public Health Nurse ☐

Physiotherapist ☐ Social Worker ☐ Occupational Therapist ☐

Early Intervention Forum ☐ Early Intervention Team ☐

Autism spectrum Disorder Services ☐

Other_____

Section 5: Parent/Guardian Consent

I consent to my child **(*please print name*)** _____ being referred by pre-school to the HSE Speech & Language Therapy Department.
I also consent to school staff consulting with and providing relevant reports to the speech & language therapist.

Name of Parent/Guardian: _____
(*please print clearly*)

Signature: _____

Date: _____

Name of Referrer: _____
(please print clearly)

Profession: _____

Signature: _____

Address: _____

_____

Telephone Number: _____

Email Address: _____

Date of Referral: _____

Eligibility & Suitability of Referrals to Primary Care speech & Language

- There is no upper or lower age limit for eligibility to receive Primary Care SLT service.
- Children do not have to possess a medical card to access this service.
- Children who are under the care of a specialist service are not eligible to access Primary Care Speech and Language Therapy Service i.e. Intellectual Disability services/ Physical Disability services/ Autistic Spectrum Disorder services/ Child and Adolescent Mental Health Services.
- Children under 5 years and 6 months of age who present with the significant indicators for the following should be referred to the appropriate specialist agency via the Early Intervention Services Intake Forum. (021-4923893)
    - Significant physical disability
    - Intellectual Disability
    - Autistic Spectrum Disorder
    - Significant needs in two or more areas of development.

- All referrals to Primary Care SLT are screened for eligibility and suitability. The referral will be accepted if it meets the eligibility criteria.
- If the referral does not appear to be appropriate to the SLT service based on the referral information, you will be contacted by an SLT and requested to provide further details. A referral to a more appropriate service may be recommended and discussed with you.
- Currently children accepted for assessment by the SLT service are seen for an Initial assessment appointment within 4 months.

Please return the completed form by post to:

Speech & Language Therapy Department
City General hospital,
Infirmary Road,
Cork.
Eircode: T12 NV97

Alternatively, scan and email to: speechtherapy.sl@hse.ie

If you have any referral queries, please phone: 021 4927801