CÚRAM SLÁINTE POBAIL
CORCAIGH CIARRAÍ
CORK KERRY
COMMUNITY HEALTHCARE

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

This form is to be used by schools to refer 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: Contact Details

Child's Name: _____

Gender: Male ☐ Female ☐

Date of Birth: _____

Address: _____

_____

_____

Telephone Number(s): _____

GP: _____

Home Language(s): _____

Is this child multilingual? Yes ☐ No ☐

If yes please answer the following:

How long has the child been exposed to English? (For example since preschool or school entry).

_____

_____

_____

Are there parental concerns about the child's level of speech and language ability in his/her mother tongue?

_____

_____

School: _____

Principal: _____

Class: _____

Class Teacher: _____

School Telephone Number: _____

School Email Address: _____

Name of referrer ***(please print)***: _____

Please complete sections 2, 3 & 5 in consultation with the child's parents/guardians

Section 2: Parent/Guardian Details

Parent 1: Name: _____

Parent 1 Address:
(if different from child's above) _____

_____

Telephone Number(s): _____

Parent 2: Name: _____

Parent 2: Address:
(if different from child's above) _____

_____

Telephone Number(s): _____

Or

Legal Guardian's Name: _____

Legal Guardian's Address: _____

If the child is in foster care please give the name of the child's Social Worker: _____

Have you ever had concerns about your child's speech, language and/or communication development? Yes ☐ No ☐

If yes, please give details: _____

_____

_____

What are your current concerns? _____

_____

_____

Section 3: Previous/Current Inputs

Has the child been referred to or attended Speech & Language Therapy before? Yes ☐ No ☐

If yes, please give details, eg: clinic attended: _____

_____

_____

Has the child been referred to or assessed by the National Educational Psychology Service? Yes ☐ No ☐
(If yes, please attach copy of the report with this referral)

Other Agencies currently involved with this child (eg: Paediatrician, Audiologist, Area Medical Officer, Public Health Nurse, Physiotherapist, Occupational Therapist, Early Intervention Team, Network Disability Team):

	Name	Address	Telephone
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Section 4: School Details

What are your concerns regarding this child's speech/language and/or communication skills? _____ _____ _____

Does/Is the child:	**Yes/No**	**Examples**
unintelligible to peers and teachers		
omits sounds from words or have difficulty saying specific sounds *		
have consistent difficulty understanding simple instructions without prompting		
have consistent difficulty understanding questions		
have consistent difficulty recalling information from a story		
have consistent difficulty understanding verbal concepts		
have consistent difficulty understanding long instructions		
have consistent difficulty following conversations		
use sentences of three to four words		

use sentences of five words or more		
use long sentences which combine two or more ideas		
use correct grammar		
hold short conversations		
retell simple stories		
participate in group discussions		
Are these skills improving?		

What are the child's strengths? _____

_____

Please comment on the child's social communication: _____

_____

_____

Please comment on the child's academic achievement: _____

_____

_____

Please describe how the child's speech/language/communication difficulties are affecting the child's communication in school: _____

_____

_____

_____

Please describe how the child's speech/language/communication difficulties are affecting the child's learning in school: _____

_____

_____

What strategies have you used that have been effective in supporting the child's speech/language/communication in school? _____

_____

_____

_____

Please give details of any standardised assessments that have been carried out: _____

_____

_____

Is the child receiving learning support? Yes ☐ No ☐

Is the child receiving resource teaching? Yes ☐ No ☐

Date of commencement: _____

Number of hours: _____

Name of Resource or Learning Support Teacher: _____

Section 5: Parent/Guardian Consent

I consent to my child **(*please print name*)** _____ being referred by 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: _____

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