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# PARENTAL SPEECH AND LANGUAGE THERAPY REFERRAL FORM

#  West Cork

*This form is to be used by parents to refer children to the HSE SLT Service*

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

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

G.P Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s first language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Pre-School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2: Referral Details**

Please state why you are referring your child to Speech & Language Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Section 3: Previous/Current Inputs**

Has your child ever attended any of the following?

 ***Please tick all that apply and provide the name and contact details.***

Paediatrician □ Audiology □ ENT □

Psychologist □ Community Medical Doctor □ Public Health Nurse □

Physiotherapist □ Social Worker □ Occupational Therapist □

Child & Adolescents Mental Health Services (C.A.M.H.S) □

West Cork Childrens Disability Network Team (WCCDNT) □

 Speech & Language Therapist □ Other ⁮ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4: Parent/Guardian Consent**

1. I consent to my child **(*please print name*)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being referred to the HSE Speech & Language Therapy Department. YES □ NO □

 2. I consent to the speech & Language Therapy Department contacting the professionals listed above in regards to my child. YES □ NO □

Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(***please print clearly***)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eligibility & Suitability of Referrals to Primary Care Speech & Language Therapy**

* There is no upper or lower age limit for eligibility to receive Primary Care Speech and Language Therapy service.
* Clients do not need to have a medical card to access the service.
* Clients who are under the care of a specialist service are not eligible to simultaneously access Primary Care Speech and Language Therapy Service i.e. WCCDNT, CAMHS
* All referrals to Primary Care Speech and Language Therapy 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 Speech and Language Therapy service based on the referral information, you will be contacted by a Speech and Language Therapist and requested to provide further details. A referral to a more appropriate service may be recommended and discussed with you.

**Please return the completed form by post to:**

Speech & Language Therapy Department

Coolnagarrane

Skibbereen

Co. Cork

Eircode: P81 HC43

 *If you have any referral queries, please phone: 028 40433*