Feidhmeannas Seirbhíse Sláinte
Health Service Executive

HSE Dublin South West Speech & Language Therapy Department,
Tallaght Cross Primary Care Centre
Tallaght Cross West
Russell Centre
Tallaght
Dublin 24

☎: **01-7957563**

PRIMARY CARE SPEECH AND LANGUAGE THERAPY REFFERAL FORM

Please complete this referral form in consultation with parent(s)/guardian(s) in order for us to process your referral.

Once complete, please sign and return to the address shown above.

PLEASE USE BLOCK CAPITALS

- **SECTION A**: To be completed for **all children**
- **SECTION B**: To be completed for children **2;11 years or younger**
- **SECTION C**: To be completed for children **3;0 years or older**
- **SECTION D**: To be completed for **all children**

SECTION A: PLEASE COMPLETE FOR **ALL CHILDREN**

Identifying Information

Child's First Name:		Child's Surname:	
Date of Birth:		Gender:	
Address:			
Email address:			
Name of Parent(s)/ Legal Guardian(s):			
Contact Numbers:			

Birth/Medical and Developmental History

Relevant **birth and medical** history *(e.g. hearing checks/illnesses)*	
Is your child meeting their other **developmental milestones**? *Give details*	
Are there any **behavioural** concerns? *Give details*	

Languages in the Child's Life

What **languages** are used at home?	
How long has the child been **exposed to English**?	
Is an **interpreter** required for assessment?	

SECTION B: PLEASE COMPLETE FOR CHILDREN AGED **2;11 YEARS OR YOUNGER**

Speech, Language, and Communication

How does your child let you know that they **want something**? *(e.g. if they want a drink? If they want you to open something?)*	*e.g. pointing, crying, reaching, taking you by the hand, looking at you, using words etc.*
Has your child achieved the following **milestones**? *(Please tick box)*	Pointing ☐ Responds to their name ☐ First Words ☐ how many are they using_____ Two words together ☐ Three words together/sentences ☐ Following everyday instructions ☐ Following instructions outside of everyday routines ☐

Play and Social Communication Development

Does your child **like you to join in** their play?	
Who else does your child like to **play** with? e.g. other children or adults	
What toys does your child like to play with at home?	*e.g. cars, blocks, household items, water, tea sets*
How does your child like to **play** with toys?	*e.g. putting into their mouth, banging toys, throwing toys, building, driving them, or pretending.*
Does your child **look at you** while interacting with you?	
Does your child do anything during **play** that you are **concerned about**?	

Education

Is your child attending **crèche or preschool**? *Please give details e.g. name, start date and how often they attend?*	
If **yes**, have staff/teachers **expressed concerns** for your child? *Please give details*	

SECTION C: PLEASE COMPLETE FOR CHILDREN AGED **3;0 YEARS OR OLDER**

Speech, Language, and Communication

Please explain how your child **mostly communicates** with you or others now?	*e.g. crying, single words, sentences*
My child **has difficulty** with: (please tick box) Extra information: _____ _____ _____ _____ _____ _____	Understanding what others say ☐ Following instructions they are given ☐ Using sentences ☐ Telling a story e.g. explaining what happened at school ☐ Having a conversation ☐ Pronouncing certain sounds *e.g. 'tup' for cup* ☐ *give examples:* Stammering ☐ Hoarseness/ Voice Concerns ☐

Play and Social Communication Development

Do you have any concerns with your child's **ability to interact** with you or others?	
Please give details of your **child's play** and **what** they like to play with?	

Education

Is your child attending **preschool or school**? *Please give details e.g. name, start date and other relevant information?*	
If yes, have staff/teachers **expressed concerns** for your child? *Please give details*	

SECTION D: PLEASE COMPLETE FOR **ALL CHILDREN**

Are there other services/agencies involved with your child's care?

Please attach all reports (with parental consent)

Name of service/agency?	Details
Occupational Therapy	
Physiotherapy	
Educational Psychology (NEPS)	
Clinical Psychology	
Paediatrician/Medical or Surgical Consultant	
Area Medical Officer	
Public Health Nurse	
Audiology	
Other (e.g. TUSLA child and family services)	
Referred to or assessed by Assessment of Need (AON)	
Referred to or waiting for another SLT service? E.g. Early Intervention Team, School Age Team, Lucena?	

What are the main concerns for you and your child?

1.	
2.	
3.	

Parental/Guardian Consent to Referral

Signed Parent(s)/Guardian(s) consent is required for this referral to be processed.

- Does the parent/guardian **consent to the referral**; Yes ☐ No ☐
- Does the parent/guardian **consent to an interpreter** if required by the Speech and Language Therapist; Yes ☐ No ☐
- Does the parent/guardian **consent to be contacted by:** Text ☐ Email ☐

Parent/Guardian Signature: _____ **Date:** _____

Referral Agent Details

Referrers Name (print)	
Referrers Signature	
Title	
Location	
Contact Details	

Please be aware that incomplete forms will be returned to sender.