

**STAMMERING SUPPORT SERVICE REFERRAL FORM**

|  |
| --- |
| **REFERRAL CRITERIA** |
| [ ]  **Child over 6 years** **AND** **their stammer is having a significant impact on their wellbeing and/or participation**[ ]  **An ADULT who stammers AND their stammer is having a significant impact on their wellbeing and/or participation****Children under 6 years old MUST meet one or both of the following criteria:**[ ]  Child’s stammer is having a significant impact on their wellbeing and participation[ ]  Parent has already attended a stammering parent workshop and would benefit from further specialist support***\*\*\*If the child/young person does not meet these criteria, please refer to the Children’s Speech and Language Therapy Mainstream service.*** |
| **DETAILS OF PERSON BEING REFERRED:** |
| **FIRST NAME:** |  | **SURNAME:** |  |
| **DOB:** |  | **Telephone Number:** |  |
| **Gender:** | **M / F** | **Mobile Number:** |  |
| **NHS Number:** |  | **Email address:** |  |
| **Address (including POSTCODE):** |  |
| **GP Name and Address:** |  |
| **School/Nursery:** |  |
| **Name of PARENT/CARER (if referring a child under 18 years):** |  | **OTHER AGENCIES/****PROFESSIONALS INVOLVED?****Please specify (e.g., Audiology, Physiotherapy, SOCIAL SERVICES)**  |  |
| **PREVIOUS OR CURRENT SPEECH AND LANGUAGE THERAPY INVOLVEMENT.**  | **Please specify:**  |
| **LANGUAGE(S) SPOKEN AT HOME:** |  | **INTERPRETER REQUIRED?** **If YES – please include specific requirements e.g., gender of interpreter, which language/dialect** |  |
| **KNOWN DIAGNOSED MEDICAL CONDITIONS:** |  |
| **CONSENT TO DISCUSS WITH CURRENT SPECIALIST SPEECH AND LANGUAGE THERAPIST?** | **Yes** [ ]  **No** [ ]   |
| **REASONS FOR REFERRAL:** |
| **What IMPACT do these difficulties have on the individual’s daily participation / wellbeing e.g. at school, at work, socially.*****\*\*Please provide as much information as possible. If full details are not given, the referral will not be accepted.*** |
| **Have you been given any advice?** |
| **Describe the intended goal for the child, person or family – related to their wellbeing/participation?** |
| **DETAILS OF REFERRER:** |
| **Name:** |  |
| **Designation:** |  |
| **Address:** |  |
| **Email:** |  |
| **Contact Number:** |  |
| **Date:** |  |

**Please note: We aim to see new referrals within 12-18 weeks of the Stammering Support Service receiving this referral.**

**This form will be returned to the referrer if it is not fully completed.**

**The completed form can be emailed to** **slt.leedsreferrals@nhs.net** **(Please note this is an administration email account for referrals only) OR via SystmOne**

Alternatively, this form can be posted to:

**CHILDREN’S SPEECH AND LANGUAGE THERAPY ADMIN TEAM, Leeds Community Healthcare, Building 3, White Rose Park, Millshaw Park Lane, Leeds, LS11 0DL**

If you have any queries please contact the Children’s Speech and Language Therapy Admin team on **TEL: LEEDS (0113) 8433650**