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This form should be completed by or in collaboration with your local Speech and Language Therapist. Please ensure your referral meets our [**referral criteria**](mailto:referral%20criteria). Referrals should be emailed to: [**thespecialistspeechclinic@cardiffmet.ac.uk**](mailto:thespecialistspeechclinic@cardiffmet.ac.uk)**.**

*Cysylltwch a thespecialistspeechclinic@cardiffmet.ac.uk os hoffech gael y ddogfen hon yn Gymraeg /*

*Please contact thespecialistspeechclinic@cardiffmet.ac.uk if you would like this document in Welsh.*

**Demographics of individual being referred**

**Heading**

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| --- | --- | --- | --- |
| Name | Click or tap here to enter text. | | |
| Date of birth | Click or tap here to enter text. | | |
| Sex assigned at birth | Choose an item. | Does the individual identify as a different gender to their sex, if so please specify | Choose an item.  Click or tap here to enter text. |
| Address | Click or tap here to enter text. | | |
| Parent/Carer  *If applicable* | Click or tap here to enter text. | | |
| Contact Number | Click or tap here to enter text. | | |
| Email | Click or tap here to enter text. | | |
| Languages spoken | By individual being referred: Click or tap here to enter text.  By parent/carer (if applicable): Click or tap here to enter text.  Is an interpreter required:  Yes, language: Click or tap here to enter text.  No | | |
| Education Setting  *If applicable* | Name: Click or tap here to enter text.  Address: Click or tap here to enter text.  *Please indicate if the child has an Individual Development Plan (IDP), Statement or Education Health and Care Plan (EHCP) in place or in progress:*  Click or tap here to enter text. | | |

**Reason for referral**

|  |  |
| --- | --- |
| Reason for referral | Click or tap here to enter text. |

**Speech, Language and Communication Skills**

|  |  |
| --- | --- |
| Attention and listening | Are they able to attend to 15 minutes of adult led activities?  Yes  No |
| Social communication | Do they have communicative intent (verbally or non-verbally e.g., AAC)?  Yes  No |
| Receptive language | Do they have age appropriate receptive language skills?  Yes  No  If no, please specify their receptive language ability: Click or tap here to enter text. |
| Expressive language | Do they have age appropriate expressive language skills?  Yes  No  If no, please specify their expressive language ability: Click or tap here to enter text.  Are they regularly combining words verbally or using AAC:  Yes  No  Are they able to attempt to imitate single words after an adult:  Yes  No |
| Speech sounds | Do you have concerns with:  Prosody  Yes  No  Don’t know  Resonance  Yes  No  Don’t know  Oro-motor skills  Yes  No  Don’t know  Consistency of word productions  Yes  No  Don’t know  Articulation of single sounds  Yes  No  Don’t know  *If yes please list sounds you are concerned about:* Click or tap here to enter text.  Use of phonological processes  Yes  No  Don’t know  *If yes please list processes you are concerned about:* Click or tap here to enter text.  Speech processing skills  Yes  No  Don’t know |
| Intervention received to target speech | |  |  | | --- | --- | | Total number of sessions to date and start date of intervention | Total number of sessions: Click or tap here to enter text.  Start date of intervention: Click or tap to enter a date. | | Type of input | Choose an item.  If other please specify Click or tap here to enter text. | | Spacing of sessions | Choose an item.  If other please specify Click or tap here to enter text. | | Duration | One off  Block of Choose an item. sessions  Ongoing  Other please specify: Click or tap here to enter text. | | Agent | Choose an item.  If other please specify Click or tap here to enter text. | | Areas that have been targeted in therapy: | Speech processing skills e.g. discrimination  Yes  No  Articulation  Yes  No  Use of phonological processes  Yes  No  Phonological Awareness  Yes  No  Consistency  Yes  No  Prosody  Yes  No  Other please specify: Click or tap here to enter text. | | Therapy targets for last 2 blocks of intervention and progress made towards them | |  |  | | --- | --- | | Target | Progress made | | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. |  |  |  | | --- | --- | | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. | |   . |

**Contact Details of Local Speech and Language Therapist**

|  |  |
| --- | --- |
| Name | Click or tap here to enter text. |
| Organisation address | Click or tap here to enter text. |
| Contact number | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| Capacity for therapy available locally | Type of sessions available Choose an item.  Agent Choose an item.  Duration Choose an item. If therapy block, number of sessions in block Choose an item.  Spacing of sessions Choose an item.  If other please specify: Click or tap here to enter text. |

**Referrer**

Please email referrals to:

**thespecialistspeechclinic**

**@cardiffmet.ac.uk**

|  |  |
| --- | --- |
| I have consent to make this referral from the individual I am referring or their  parent/carer  Yes  No | |
| Signed |  |
| Name and Job Title | Click or tap here to enter text. |
| Date | Click or tap to enter a date. |

**Supporting Documents to Attach Alongside Referral Form**

Case History form

Intelligibility in context scale (please complete a separate form for each language spoken)

Copy of most recent speech assessment

Copy of most recent SLT report