



Physical Development (Please give details of any known problems with physical development, hearing, vision, co-ordination or medical problems):

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**Please attach 2/3 year screening tool /ECAT form if applicable**

**Hearing Test results:**

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Is this a parental request for referral? No  Yes

Referral reason: (more than one box can be ticked)

- |  |  |
|--|--|
| <input type="checkbox"/> Eating and drinking     | <input type="checkbox"/> Voice                             |
| <input type="checkbox"/> Unclear sounds          | <input type="checkbox"/> Difficulty following instructions |
| <input type="checkbox"/> Unusual use of language | <input type="checkbox"/> Difficulty using sentences        |
| <input type="checkbox"/> Hearing Impairment      | <input type="checkbox"/> Dysfluency/stammering             |
| <input type="checkbox"/> Social Communication    | <input type="checkbox"/> Other.....                        |

Summary of current concerns (give reasons for referral at this time - giving as much detail as possible):

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**FOR PARENT/CARER SIGNATURE.**

***I give permission for my child to be referred to the Speech and Language Therapy Service and agree to bring him/her to a local clinic for appointments:***

Signed: ..... Date: .....

Please state what you would like this referral to achieve for your child: .....

.....  
.....

**TO BE COMPLETED BY REFERRER**

REFERRED BY:.....DESIGNATION: .....

Signature: .....

Date: ..... Tel: No.: .....