

THAMESIDE COMMUNITY HEALTHCARE NHS TRUST  
**District Speech and Language Therapy Service**  
**REFERRAL**

Please complete fully in block capitals.  
Any incomplete or illegible forms will be returned unprocessed.

<b>NAME: Surname</b>	<b>First name(s)</b>
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**ADDRESS:**

**DATE OF BIRTH:**

**GP:**

**TELEPHONE No:**

**SCHOOL/PLAYGROUP:**

**RELEVANT FAMILY INFORMATION:**

**RELEVANT MEDICAL INFORMATION (e.g. general development, health, tonsils and adenoids, syndromes, medication . . . . )**

**HEARING TEST (dates and results)**

**OTHER AGENCIES INVOLVED (e.g. Consultant, ENT, Ed Psychs, Social Services, Nurseries, Playgroups . . . . )**

**PLEASE COMPLETE DETAILS OVERLEAF . . .**

**REASON FOR REFERRAL** (please tick)

CONCENTRATION/ATTENTION

good	<input type="checkbox"/>
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fair	<input type="checkbox"/>
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poor	<input type="checkbox"/>
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UNDERSTANDING OF LANGUAGE

good	<input type="checkbox"/>
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fair	<input type="checkbox"/>
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poor	<input type="checkbox"/>
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USE OF LANGUAGE

non-verbal	<input type="checkbox"/>
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single words	<input type="checkbox"/>
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sentences of 2-3 words	<input type="checkbox"/>
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sentences 4 words +	<input type="checkbox"/>
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conversation	<input type="checkbox"/>
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**SOUND SYSTEM** (please give examples, e.g. t, p, s, f)

sounds used

sounds not used

sound system normal
yes/no

STUTTER/STAMMER

yes	<input type="checkbox"/>
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no	<input type="checkbox"/>
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MOVEMENTS OF TONGUE AND LIPS

normal	<input type="checkbox"/>
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abnormal	<input type="checkbox"/>
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FEEDING AND SWALLOWING

normal	<input type="checkbox"/>
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abnormal	<input type="checkbox"/>
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DESCRIPTION OF SPEECH AND LANGUAGE/COMMUNICATION

ANY OTHER RELEVANT COMMENTS/INFORMATION

PATIENT/CARER AGREED TO REFERRAL

yes	<input type="checkbox"/>
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no	<input type="checkbox"/>
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Signed \_\_\_\_\_

Name (PRINTED) \_\_\_\_\_

Date \_\_\_\_\_

Designation \_\_\_\_\_