**Referrals to Speech and Language Therapy/ Early Years Language Development Service (EYCLDS) pathway:**

**Referral criteria for the Early Years Communication and Language Development Service (EYCLDS)**

*Please refer to the EYCLDS Pathway document.*

*Before making the referral children should have accessed the following from the pathway* [*https://indd.adobe.com/view/5b5581df-6962-4b27-8296-9746bf03ae14*](https://indd.adobe.com/view/5b5581df-6962-4b27-8296-9746bf03ae14)

***Don’t forget you can contact EYCLDS at any point for advice and guidance on 01204 338349***

Early Years Communication and Language Development Service (EYCLDS)
Healthy Families (0-19 Service)
Oxford Grove Start Well Centre
49-55 Shepherd Cross Street
Bolton BL1 3BY
01204 338349/ 338182

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| --- |
| **Every Child Offer*** High quality adult interaction and language rich environments wherever the child spends time.
* Consistent use of the 5 Golden Rules of Early Language and Communication Development by parents and educational setting.
* Assessment tools:
	+ Ages & Stages Questionnaire – 3 (ASQ-3)
	+ Ages & Stages Questionnaire – SE (ASQ-SE)
	+ Communication & Language Journey
	+ Newborn Behavioural Observations
	+ Early Years Foundation Stage (EYFS)
 |
| **Getting ‘Extra Help’ from those already involved:*** Complete a Wellcomm Assessment
	+ Green = Continue with ‘Every Child’ offer.
	+ Amber = Carry out appropriate activity from the Big Book of Ideas (BBI) with family and reassess after 3 months. Consider signposting to a [Let’s Get Talking group](https://www.boltonstartwell.org.uk/downloads/file/754/referral-for-lets-get-talking-6-week-online-sessions-).
	+ After reassessment, if child continues to score Amber, continue with reassessment and contact EYCLDS for advice and guidance.
	+ Red = Carry out appropriate activities from BBI, plus contact EYCLDS for specific Information, Advice and Guidance (IAG).
	+ Other interventions include: Nursey Narrative, EYBIC.
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**Refer to EYCLDS if the child meets the below criteria, continuing with the intervention (BBI activities) until the child has been seen**

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| --- |
| **Getting ‘More Help’ from additional agencies:**Criteria summary:* Child is between 18 months and 4 years.
* Child is presenting with language and communication difficulties and has scored RED on their review Wellcomm.
* It can be demonstrated that the activities and advice from the BBI has been implemented between Wellcomm assessments.

**If there are concerns regarding the child's social communication skills, please contact EYCLDS prior to making the referral.****Requests received that have not demonstrated evidence of two Wellcomm assessments and consistent use of the BBI interventions will be rejected.**  |

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| **How to access EYCLDS:** |
| **What information to include to access EYCLDS…****“In addition to a relevant holistic assessment”** for the young person, information about strengths and needs in the following areas should be provided in the **Speech, Language and Communication** section of the Early Help Assessment or on the single agency referral form (depending on the child’s needs):* Attention and Listening
* Play and social skills
* Understanding
* Talking and speech sounds
* Feeding/swallowing issues
* Information about what steps have been made to address these concerns to date, e.g. WellComm scores and activities shared with family, family attended “Let’s get Talking”.

**NB: Bilingual requests** - please state **ALL other languages spoken in the home** regardless of need for interpreters. We need this information to assess the child in their first language, as well as in their second language. This means that we will need to book an appropriate interpreter to help the Speech and Language Therapist complete this assessment process. *Please specify if a child is already known to an independent or private Speech and Language Therapist and include their details in the other professionals involved section. This is so that liaison between SLTs can take place with parental permission.* |
| **Additional Important Information:** |
| * Where children are presenting with Social Communication difficulties, please contact EYCLDS prior to making the referral.
* The Wellcomm assessment should be completed with all children where there are concerns with their communication skills. If due to the child’s current level of ability it is not possible to complete the Wellcomm starting at their chronological age Section, then Sections 1 and 2 should be completed at a minimum. These Sections are observation based.
* Where the communication concerns are specifically around speech sounds, or in the case of re-referrals, referrals will be accepted without needing 2 WellComm assessments to be completed 12 weeks apart:
* **Speech Sounds** - if it is clear all other areas of the child's language and social communication needs are developing typically, they may be seen by EYCLDS. One set of Wellcomm scores should be included to rule out delayed language development.
* **Re-referrals** - these children have previously met the criteria and have previously accessed the service. For these children, if it is clear that it is a re-referral and a small update on the progress the child has/hasn’t made since they last accessed the service is provided, they can access EYCLDS without evidence of Wellcomm scores.
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# SPEECH SOUND DEVELOPMENT CHECKLIST

Please consider the child’s abilities in relation to this speech sound development checklist:

|  |  |  |  |
| --- | --- | --- | --- |
|  | AGE 3 YEARS |  |  |
|  | NOT A CAUSE FOR CONCERN | POSSIBLE CAUSE FOR CONCERN |  |
|  | Speech usually understood by family, but strangers may struggle. | Family members find speech difficult to understand most of the time.  |  |
|  | Using a range of consonant sounds. | Only using one consonant sound, e.g. uses /h/ to replace most consonants. |  |
|  |  |  |  |
|  | AGE 3 ½ - 4 YEARS |  |  |
|  | NOT A CAUSE FOR CONCERN | POSSIBLE CAUSE FOR CONCERN |  |
|  | Speech usually understood by family, but strangers may struggle. | Family members find speech difficult to understand most of the time. |  |
|  | Fricative sounds: ‘f, g, v, s, z, sh’ may not be used yet and child may replace these sounds with a shorter sound e.g. sun 🡪 dun, house 🡪 hout. | Missing of beginnings of words e.g. car 🡪 ar, dog 🡪 og. |  |
|  | Sounds ‘t’ and ‘d’ used for ‘c/k’ and ‘g’ e.g. coat 🡪 toat, girl 🡪 dirl. | Sounds ‘c/k’ and ‘g’ used to replace ‘t’ and ‘d’ e.g. teddy 🡪 keggy, dog 🡪 gog. |  |
|  | Consonant ‘blends’ reduced e.g. spider 🡪 pider, dress 🡪 dess. | Only using one consonant sound, e.g. uses /h/ to replace most consonants. |  |
|  | Interdental ‘lisp’ e.g. sun 🡪 thun or ‘slushy’ /s/ sound. |  |  |
|  | ‘r’ and ‘l’ replaced by ‘w’ e.g. red 🡪 wed, lip 🡪 wip |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | AGE 4 ½ - 5 YEARS |  |  |
|  | NOT A CAUSE FOR CONCERN | POSSIBLE CAUSE FOR CONCERN |  |
|  | Speech understood most of the time.  | Speech always difficult to understand. |  |
|  | Sounds such as ‘sh, ch, j, r, th, y’ not used clearly e.g. shoe 🡪 soo/doo, chair 🡪 tair, yellow 🡪 lellow. | The sounds ‘t, d, c/k, g, f, s’ not yet used correctly at 5+ years of age. |  |
|  | Consonant blends e.g. ‘tr, fl, st, sm’ not always used clearly e.g. flower 🡪 fwower, stop 🡪 top/dop. |   |  |
|  | Interdental ‘lisp’ e.g. sun 🡪 thun or ‘slushy’ /s/ sound. |  |  |
|  | ‘r’ and ‘l’ replaced by ‘w’ e.g. red 🡪 wed, lip 🡪 wip. |  |  |

**By 5½ years old most speech sounds should be in place, if not then a referral to the service would be indicated using a single agency referral form or Early Help assessment.**

**SPEECH AND LANGUAGE THERAPY SERVICE REFERRAL FORM**

***PLEASE REFER TO THE REFERRAL FLOWCHART TO ENSURE THE CORRECT REFERRAL PATHWAY HAS BEEN FOLLOWED FOR THIS CHILD.***

**PLEASE NOTE: A referral can only be accepted if ALL sections are completed and consent from the person with parental responsibility for the child is included. *INCOMPLETE FORMS WILL BE RETURNED.***

**Child’s details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Child**  |  | **Date of Birth** |  |
| **Address** |  | **Postcode** |  |
| **Contact Numbers**  |  |
| **Parent/ carer name(s)** |  |
| **Do parents/ carers have any literacy, learning or communication needs?**  | **Yes/ No** |
| **Languages (and dialect) spoken in the home** |  | **Interpreter needed?**  | **Yes\*/ No** *\*Interpreter Language:* |
| **GP Name**  |  | **GP Address** |  |
| **Education setting** |  |
| **Are parents/ carers ready to engage with services to support their child’s speech, language and communication needs?** | **Yes/ No\*** *\*If no, please provide details below* |

**Additional information:**

|  |
| --- |
| **Please provide information regarding:*** **Referrals made/ stage of input e.g. Audiology, Paediatrics**
* **Involvement of any outside agencies such as private therapists or relevant charities**
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**\*\*PLEASE CONSIDER THAT IF A CHILD IS KNOWN TO MULTI-DISCIPLINARY TEAMS, AN EARLY HELP ASSESSMENT MUST BE IN PLACE AND SUBMITTED ALONGSIDE THIS REFERRAL\*\***

**SPEECH, LANGUAGE AND COMMUNICATION DIFFICULTIES**

**Please ensure you have evidence and information regarding each area of concern regarding the child’s communication to support a referral at this point.**

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| --- | --- |
| **Please tick which areas the child is experiencing difficulties with:** | **Please comment how these difficulties are affecting the child:** |
|  | **Attention and listening skills**  |  |
|  | **Early communication skills** *e.g. turn taking, play, eye contact, pointing.* |  |
|  | **Ability to understand language** |  |
|  | **Ability to use language** *e.g. speech, signs, symbols, communication aids.*  |  |
|  | **Clearness of speech***\*consider against speech sound norms checklist in relation to typical speech sound errors and the age at which this would be an area of concern.* |  |
|  | **Social interaction skills** |  |
|  | **Stammering** |  |
| **Strategies/ interventions currently in place:** |
| **Additional notes/ information relevant to this referral e.g. feeding concerns, reported carer concerns (not observed by referrer)** |

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| **Wellcomm Tool Information****Please start at the section for the child’s chronological age and work backwards, stopping the assessment when they score ‘green’.** **See EYCLDS referral criteria for referrals whereby the main concern is speech sounds or this is a re-referral.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of 1st screen | Age in months at time of 1st screen  | Section | Score out of 10 | Red/Amber/Green | Which activities from Big Book of Ideas have been shared and demonstrated? E.g. 3.4, 3.5 etc.  |
|  |  | 8 |  |  |  |
|  |  | 7 |  |  |  |
|  |  | 6 |  |  |  |
|  |  | 5 |  |  |  |
|  |  | 4 |  |  |  |
|  |  | 3 |  |  |  |
|  |  | 2 |  |  |  |
|  |  | 1 |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| Date of 2nd screen (at least 12 weeks later) | Age in months at time of 2nd screen  | Section | Score out of 10 | Red/Amber/Green | Comments  |
|  |  | 8 |  |  |  |
|  |  | 7 |  |  |  |
|  |  | 6 |  |  |  |
|  |  | 5 |  |  |  |
|  |  | 4 |  |  |  |
|  |  | 3 |  |  |  |
|  |  | 2 |  |  |  |
|  |  | 1 |  |  |  |

**ASQ-3/ ASQ SE scores:****Please include relevant scores here:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Section | Score | White/ Grey/ Black |
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Additional narrative as applicable:

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**CONSENT FORM**

**Please note consent must be obtained from the person with parental responsibility for the child.**

**CONSENT FOR REFERRAL TO THE SPEECH AND LANGUAGE THERAPY SERVICE**

**As the person with parental responsibility for the child named below, I give consent for:**

* My child to be referred to the Speech and Language Therapy Service by the named person below.
* My child to access both a virtual and face to face service, depending on their presenting needs and support required during the period of care following this referral.
* The Speech and Language Therapy Service to liaise and consult with other people involved with my child, in relation to their needs.
* The Speech and Language Therapy Service to share information with other services involved with my child, in both verbal and written formats.

Verbal consent can be gained by health professionals but all other referrers need to obtain written consent for this referral to be accepted:

|  |  |
| --- | --- |
| **Child’s name:** |  |
| **Parent/ carer name:**  |  |
| **Relationship to child:**  |  |
| **Verbal consent** *(if health professional):*  | Yes/ No |
| **Written consent** *(parent/ carer to sign):* |  |
| **Date:**  |  |

**Referral made by:**

|  |  |
| --- | --- |
| **Referrer’s name:** |  |
| **Signature:**  |  |
| **Job title:**  |  |
| **Base/ address** (including postcode) |  |
| **Telephone contact details:** |  |
| **Email contact details:** |  |
| **Date of referral:**  |  |

**What’s next?**

**Please take a copy and send this referral form via:**

1. **Email to:** paedcommtherapyreferrals@boltonft.nhs.uk

**The child’s parent/ carer will then receive a letter giving them further information regarding access to an initial appointment with the Speech and Language Therapy service.**