Speech and Language Therapy Referral Form

Date: Referrer's name:

Down Syndrome Ireland Branches

Please select the box for the branch in which you are making this referral to:

☐ Galway ☐ Dublin ☐ Tipperary ☐ Kildare

☐ Limerick ☐ Cork ☐ Clare

Client Information

Surname: First name:

DOB: Gender:

Address:

Country of birth:

First Language:

Other languages:

If English is their second language, how long have they been exposed to it?

Years Months

Interpreter required: ☐ Yes ☐ No

Next of Kin

Parent/Guardian:

Relationship to client:

Telephone: Email:

Address (if different):

Parent/Guardian:

Relationship to client:

Telephone: Email:

Address (if different):

Names of siblings and their ages:

Relevant family history:

General practitioner details

GP Name/Practice:

Telephone:

Other health care professionals previously/currently involved

- ☐ Speech & Language Therapy
- ☐ Occupational Therapy
- ☐ Children's Disability Network Team
- ☐ Child & Adolescent Mental Health Services
- ☐ Physiotherapy
- ☐ Audiology
- ☐ Optometry
- ☐ Psychology

Medical History

Relevant Medical History i.e., birth history, history of hospitalisations, etc.

Current medications:

Allergies:

Dual diagnosis: ☐ ADHD ☐ ASD ☐ Other:

Hearing: ☐ No hearing loss ☐ Hearing loss ☐ Retest needed

Eyesight: ☐ No difficulties ☐ Requires glasses ☐ Retest needed

Does this individual have any difficulties with feeding? If so, please specify:

☐ Feeding ☐ Eating ☐ Drinking ☐ Swallowing

Does this individual have any sensory needs e.g., sensitivity to loud sounds, clothing/food textures, etc.? If so, please specify:

Does this individual have any behavioural problems? If so, please specify:

Education Details

Name of establishment:

Address:

Telephone:

Email:

Class/year:

Teacher:

SET/SNA:

Telephone:

Email:

Day Service

Name of establishment:

Address:

Telephone:

Email:

Key worker:

Telephone:

Email:

Reasons for Referral

What are the main concerns for this individual's speech, language, and/or communication development?

Please note any impact this is having on person e.g., frustration, access to, academic or employment opportunities, relationships, their well-being, etc.

Areas of speech, language, and/or communication to be developed:

☐ **Play** e.g., areas of play to be developed to create opportunities to learn

☐ **Interactions** e.g., developing communication with people

☐ **Understanding language** e.g., following directions

☐ **Spoken language** e.g., communicating their wants and needs using words

☐ **Speech** i.e., the way words are pronounced

☐ **Stammer** e.g., repeating sounds, words, or phrases

☐ **AAC (Augmentative and Alternative Communication)** i.e., Lámh signs, visuals, a communication device etc.

☐ **Something else** _____

Please include any other information that would be useful:

Consent

Referrals without signed consent of parent(s)/ guardian(s) cannot be accepted. It is required by law that at least one of the child's legal guardians consents to the referral and signs this form. It is advisable that both parents/legal guardians are aware of this referral.

I give permission for my child to be referred to Speech and Language Therapy within my local Down Syndrome Ireland Branch. ☐ Yes ☐ No

I give permission for my information/information about my child to be held by my local Down Syndrome Ireland Branch Speech and Language Therapy Department in accordance with obligations under the Data Protection Acts 1988, 2003 and 2018. ☐ Yes ☐ No

Name of Parent/Guardian: _____

Signature: _____

Date: _____

Name of Parent/Guardian: _____

Signature: _____

Date: _____

Thank you for taking the time to fill in this referral form.

This information will provide the SLT team with the information needed to move forward with your request. We look forward to working with you.