Michael Palin Centre for Stammering Children,
Finsbury Health Centre, Pine Street, London EC1R 0LP
Tel. 0207 530 4238
Email: mpc.admin@islingtonpct.nhs.uk
Website: www.stammeringcentre.org

REFERRAL FORM

Family Information

Both parents are invited to attend the consultation with their child and it is essential that we are fully informed about any family circumstances where this would not be appropriate, e.g. single parent, separated, divorce, or if an alternative partner should be included. (Please contact us if you would like to discuss this further). In order for this referral to be accepted, please make sure that you complete all details on the form before sending it to us.

CHILD:

First name: Surname:

Date of birth: Sex:

NHS number:

Home address:

Postcode:

MOTHER:

First name: Surname:

Title: (e.g. Ms, Mrs, Dr) NHS number:

Date of birth: Occupation:

Address (if different from above):

Postcode: email:

Telephone: work: home: mobile:

FATHER:

First name: Surname:

Title: (e.g. Mr, Dr) NHS number:

Date of birth: Occupation:

Address (if different from above):

Postcode: email:

Telephone: work: home: mobile:

OTHER RELEVANT CARER DETAILS:

E.g. Single parent, separated, divorced, details of stepfather/mother, other carers with parental responsibility or access etc.

Name(s): Relationship to child:

Contact details:

SCHOOL/NURSERY:

Name:

Address:

Postcode:

Head Teacher: Telephone:

FAMILY DOCTOR:

Name:

Address:

Postcode: Telephone:

BILINGUALISM OR MULTILINGUALISM:

Languages spoken in the home:

Interpreter required: Child:Yes/No Parents:Yes/No Language:

REASON FOR REFERRAL: Please be as specific as you can about why this child has been referred for an assessment. This will ensure that we arrange the assessment to best meet the needs of both therapist and family. Please tick as appropriate and give details:

- ☐ **for advice and guidance about management**
- ☐ **for possible inclusion on an intensive course**
- ☐ **for therapy to take place at MPC**
- ☐ **other**

SPEECH AND LANGUAGE ASSESSMENTS:
We require an up-to-date assessment of the child's receptive and expressive language skills. This should be comprehensive, include standardised results and reflect a range of language domains and functions. Since this information will inform the management recommendations, it is essential that this information is received prior to an assessment appointment at MPC. Please use additional sheets as necessary.

Please attach copies of any recent reports

DETAILS OF ANY PREVIOUS THERAPY AND PROGRESS:

ANY OTHER NEEDS THAT ARE/ARE NOT BEING MET:

OTHER PROFESSIONAL INVOLVEMENT:
(including contact details as appropriate)

DETAILS OF REFERRING THERAPIST:

Name:

Clinic address:

Postcode: NHS Trust / Consortium:

Telephone number(s):

Date of referral:

DETAILS OF ATTENDING THERAPIST (if different from above):
Name:

Clinic address:

Postcode: Family known to therapist? Yes/No

Telephone number(s):

SPEECH AND LANGUAGE THERAPY SERVICES MANAGER:
Name:

Contact address:

Telephone number: NHS Trust / Consortium:

Thank you. Please do not hesitate to contact us on 020 7530 4238 if you have any questions about the information we require or the arrangements for the consultation.

Internal use only:

Date received: