**Aberdeen City Health and**

**Social Care Partnership**

**Speech and Language Therapy Service**

**Request for Assistance**

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| --- |
| **Please tick to indicate that:** |
| * **Universal supports have been tried and are in place for the child / young person.**
 |  |
| * **The person completing the Request for Assistance:**
 |
|  **Has obtained informed Parent / Carer Consent / Signature for the request** |  |
|  **Has signed the form themselves** |  |
| **If these boxes have not been ticked the form WILL NOT be accepted and will be returned.** |

|  |  |
| --- | --- |
| Child / Young Person’s Name |  |
| Date of Birth / CHI |  |
| AddressPost code |  |
| Parents / Carers Names and relationship to Child / Young Person |  |
| Parents / Carers Contact Number/s |   | *Can we leave a message/text?* Yes / No  Yes / No |
| Best time to contact Parents / Carers |  |
| Parent / CarersE-mail address/s |   | *Can we contact you via email?* Yes / No  Yes / No |
| Language/s spoken at home |  | *Do the family require an Interpreter?* Yes / No |
| Early Years Setting / School  |  | *Early Years Days / Hours (please specify am / pm / full-time):* |
| GP Name & Address |  |
| Health Visitor Name and Address |  |

**Reasons for Requesting Assistance from Speech & Language Therapy**

|  |  |
| --- | --- |
| What are the current concerns about the Child / Young Person’s speech, language and communication skills? |  |
| Who has these concerns? |  |
| What are the Child /Young Person’s thoughs / concerns about their own speech, language and communication skills? *If appropriate.* |  |
| What impact are these concerns having on the …Child / Young Person?Their Family?In their eductation setting / school? |  |
| What specific change do you hope we can make for the Child / Young Person? |  |
| Are there any concerns regarding the Child / Young Person’s Hearing? | *Has a referral been made to Audiology? Yes / No**If Yes, what are the results if know:* |
| Are there any concerns other than speech, language and communication skills? Please specify: | *Has a referral been made to Dept CCH? Yes / No* |
| Any additional information that would be helpful for us to know? Medical / social / family circumstances / support to attend appointments etc. |  |
| Has the Child / Young Person been known to Speech and Language Therapy in the past? |  |

**Universal Supports**

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| --- |
| Which universal supports have been tried or are currently in place for the Child / Young Person? |
| Website Advice (www.aslt.scot.nhs.uk) |  | Advice Line |  |
| Early Language Development Videos |  | Speech Sound Development Videos |  |
| Highland Literacy Words Up Key Messages |  | CIRCLE Resources |  |
| SCERTS |  | Visual Supports (e.g Now-Next / Timetables) |  |
| Makaton |  | Early Talkboost / Talkboost |  |
| Other (Please describe below) |  |  |  |
| Please describe what you have tried or is currently in place for the Child / Young Person: |
| What difference has this made? |

PARENT / CARER CONSENT

Parent / Carer consent is a requirement for this request for assistance.

* Verbal consent is sufficient if the request is from a GP or Health Visitor. Please record in the signature box that informed consent has been given and by who.
* Signed consent is required if the request is from all other Health Professionals and Education Staff – Nursery / School.

Please complete and sign here:

|  |
| --- |
| Consent*I consent to making this request for assistance and understand that SLT staff will access my child’s health records in line with NHS Grampian policy.* |
| Name and Relationship to the Child / Young Person |  |
| Signature |  |
| Date |  |

Request for Assistance Signature

|  |  |
| --- | --- |
| Name of person Requesting Assistance |  |
| Relationship to Child / Young Person |  |
| Address |  |
| Contact Number |  |
| Email Address |  |
| Signature |  |
| Date |  |

Please be aware that the outcome of this Request for Assistance will be one of the following:

**Reassurance; Providing Advice; Assessment; and**

**Support from SLT Services as Appropriate**

Please send to:

Speech and Language Therapy Department

Airyhall Clinic

Springfield Road

Aberdeen

AB15 7RF

Or email:

gram.saltnewrequestforassistance@nhs.scot

**Please note that email addresses that do not have one of the following extensions in the address are not secure:**

**nhs.scot, gsi.gov.uk, gse.gov.uk, gsx.gov.uk, scn.gov.uk, cjsm.net, pnn.police.uk, mod.uk, mod.gov.uk , hscic.gov.uk**

If this applies to you, be aware that the information you send electronically is not secure and confidentiality may be compromised. You may prefer to post rather than email your request for assistance.