Wye Valley NHS
NHS Trust

OPT-IN QUESTIONNNAIRE

Speech and Language Therapy Service

The Speech and Language Therapy department have received a referral for your child to be assessed by a Speech and Language Therapist**. In order for your child to be offered an appointment, this form needs to be completed and returned within 14 days**. If we do not receive your form within 14 days, we will assume that your child no longer requires our service and **will be removed from the waiting list**. Once we have received your form, we will send an appointment confirming a day, time and location as soon as we have an appointment available.

Child's Name:	**Date of birth:**
The name they like to be called (if different from above):	
Name of person completing this form:	

Who lives at home?		
Full name	Age (of children)	Relationship to child
1.		
2.		
3.		
4.		
5.		
6.		

Does your child go to nursery / childminder / school?

☐ **Yes** ☐ **No**

Setting(s) my child attends: (please list)	**Day(s) attends:**	**Time attends:**
	Monday	
	Tuesday	
	Wednesday	
	Thursday	
	Friday	

Please tick any of the following, if they currently apply to your child:

- ☐ My child receives 1 to 1 support
- ☐ My child has a statement / EHC Plan
- ☐ My child has a CAF

Please tick if any of the following professionals / services are currently involved with your child:

- ☐ Paediatrician
- ☐ Educational Psychologist
- ☐ CAMHS
- ☐ Health Visitor or School Nurse
- ☐ Social Worker
- ☐ Audiology
- ☐ Occupational Therapist
- ☐ Physiotherapist
- ☐ Portage
- ☐ Other (please specify).....

What does your child like doing at home?

Does your child have any allergies? If so, please give details:

Is there anything you would like to tell us about your child's medical or developmental history?
(e.g. medication, operations, convulsions):

When was the last time your child had a hearing test?

Does your child have any hearing problems? If so, please give details:

What are your concerns about your child's speech and language development? Please tick any of the following skills that you are concerned about:

- ☐ Clarity of speech / pronunication of words
- ☐ Attention, listening and concentration
- ☐ Understanding words and sentences
- ☐ Using words and sentences
- ☐ Voice difficulties (e.g. loss of voive, strained or husky)
- ☐ Stammering
- ☐ Play and social interaction
- ☐ Behaviour
- ☐ Eating and drinking difficulties
- ☐ Other (please specify below)

Details of other concerns?

How do you feel Speech and Language Therapy could help your child?

I give my consent to (please tick):

☐ The Speech and Language Therapy Department liaising with other professionals/services involved in my child's care

☐ The Speech and Language Therapy Department leaving phone messages regarding my child's appointments, if they are unable to make contact.

You can return this form to us by:

Using the enclosed addressed envelope **OR** emailing a scan/photo to salt.hereford@nhs.net

☐ I can confirm that by returning this form by email I understand that data cannot be exchanged securely by this method of communication

I give permission for messages to be left on the following phone number/s……..

Signed: …… **Date**: ……