

PARENT/GUARDIAN REFERRAL FORM
Please return this form to the address above

Child's name:	Date of Birth:
Address:	Telephone
Postcode <i>(required)</i>	Home:
School / Nursery:	Mobile:
GP:	
Parent / Carer <i>(name and relationship to child)</i>	
Health Visitor:	Tel number, team and base:
Reason for Referral:	
Allergies: <i>(Please tick box as appropriate)</i>	
Does the child have any known allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes please give details:	

Ethnicity:

Under the Race Relations Amendments Act 2000 the Trust is legally committed to eliminating discrimination, promoting equality of opportunity and promoting good race relations. In order to work towards these goals we are required to collect ethnicity of all patients.

Please tick one of the following boxes:

- | | | |
|--------------------------------------|---|---|
| A – White | <input type="checkbox"/> British | |
| | <input type="checkbox"/> Irish | |
| | <input type="checkbox"/> Any other White Background | |
| B - Mixed | <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> White and Black African |
| | <input type="checkbox"/> White and Asian | <input type="checkbox"/> Any Other Mixed Background |
| C – Asian or Asian
British | <input type="checkbox"/> Indian | <input type="checkbox"/> Pakistani |
| | <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Any Other Asian Background |
| D – Black or Black
British | <input type="checkbox"/> Caribbean | <input type="checkbox"/> African |
| | <input type="checkbox"/> Any Other Black Background | |
| E – Chinese or Other
Ethnic Group | <input type="checkbox"/> Chinese | <input type="checkbox"/> Any Other Ethnic Group |

All the information we receive will be used and treated with the strictest confidence. Any planning information on general release will be anonymous with all names removed.

The classification is entirely voluntary but will help us to provide a better quality of care. The level of care you will receive will not be affected by your decision to complete this form.

Parent/carer consent *(required)*

I give my consent for a referral to the Speech and Language Therapy Service and I agree that information about my child may be shared with other agencies when it is in his/her best interests.

Parent/carer's signature:

Date: