**SLT Virtual Consultation Form**

The following form will provide us with an outline of your concerns so that we can use our time efficiently in providing you with relevant, beneficial suggestions for you and your child. Please include any information that you feel may be valuable for us to know ahead of the consultation.

Child’s name: Parents name:

Date of birth: Parents contact details:

**Is your child experiencing difficulty with the following? Please tick if applicable**

|  |  |  |  |
| --- | --- | --- | --- |
| **Language comprehension (receptive language)**  Following short/longer instructions, understanding what is being said by others |  | **Expressive language**  Using single words, constructing and using phrases and sentences, telling stories to communicate with others |  |
| **Speech**  Being understood by others, saying particular sounds |  | **Conversation skills**  Engaging in conversations with peers and others |  |
| **Attention and interaction:**  Maintaining attention for periods of time, attending to others’ choices of activity, engaging with others in a group/mixing |  | **Social skills**  Turn taking, sharing, group participation |  |
| **Play**  Engaging with others to play, using imagination in play |  | **Voice**  Use of voice, vocal nodules |  |
| **Fluency**  Stammering resulting in reduced fluency when speaking |  | **Sensory regulation**  Incl. sustained focus, transitioning, frustration tolerance, emotional regulation |  |
| **Other ( please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |

**What are your main concerns?**

**Have you tried any techniques that have assisted you? If so, please name them.**

**Have you tried any techniques that have not worked for you? If so, please name them.**

**On a scale of 1 (low) – 5 (high) – how significantly are your child’s difficulties impacting on:**

Performance at school: 1 2 3 4 5

Home and Family life: 1 2 3 4 5

Relationships with peers: 1 2 3 4 5

**Does your child have one of the following diagnoses?**

|  |  |  |  |
| --- | --- | --- | --- |
| Developmental Delay |  | Down Syndrome |  |
| Developmental Language Disorder (DLD) |  | Autism Spectrum Disorder (ASD) |  |
| Receptive/Expressive Language Delay/Disorder |  | Intellectual Disability/ Learning Difficulties |  |
| Phonological Delay/Disorder |  | Hearing Impairment |  |
| Articulation Disorder |  | Developmental Coordination Disorder |  |
| Voice Disorder |  | Other Neurodevelopmental Disorders |  |
| Cleft Palate |  |  |  |

**Has your child received intervention/support from other services? If so please outline:­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who has referred you to our service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank you for taking your time to complete this form.**