REFERRAL TO ADULT SPEECH AND LANGUAGE THERAPY SERVICE

Please complete **ALL** sections on both sides of this form. **Failure to complete fully may result in form being returned to referrer** *(Please note there are two pages)*

Name: **Date of Birth:** **Male/Female:**
Title: Mr/Mrs/Ms/Dr/Other **Ethnic Group:**
NHS Number:

Address:

Postcode:

Telephone: **Mobile No:**

Consent to send Text Reminders **Yes ☐ No ☐**

Name of Next of Kin: **Relationship:**

Address: **Telephone:**

GP: **Address:**

Telephone: **Consultant:**

Current Medical Info:

Past Medical Info:
(Including dates)

Medications:

Has client been seen by a Speech and Language Therapist in the past?

Yes ☐ **No** ☐ **If yes, please provide details**

Reason for referral:
Communication ☐ **Swallowing** ☐ (Please move on to next page if swallowing only)

NB VOICE REFERRALS CAN ONLY BE ACCEPTED FOLLOWING A CURRENT ENT REFERRAL (within 12 months)

Communication **Please answer ALL questions.**

Please comment on the nature of the client's communication difficulty:

____

____

How long has the client experienced communication difficulty? ______________________________

How well can the client communicate their basic needs? ______________________________

____

What is the impact of their communication difficulty on social participation/ family activity? ____

____

____

What level of concern does the client/carer have about the communication difficulty? ___________

SAMPLE - DO NOT USE

__Swallowing__ **Please answer ALL questions.**

Please comment on the nature of the client's swallowing difficulty:

How long has the client experienced swallowing difficulties?

1) What is the client's current diet? (please circle) — IDDSI Level 4 puree / Level 5 minced and moist / Level 6 soft & bite-sized / Level 7 normal

2) What is the client's current drink consistency? (please circle) — Normal / IDDSI Level 1 / Level 2 / Level 3 / Level 4

3) Is the client able to self feed?

4) What level of concern does the client demonstrate about their swallowing difficulty?

Have any of the following been observed during/after eating and drinking? (please circle):

Coughing/Choking	Yes/No (If so, on food/ fluids/ both) How frequent?
Wet sounding voice	Yes/No
Shortness of breath	Yes/No

Has the client experienced any of the following in the last 12 months:

Weight loss	Yes/No (If so, how much?)
Chest Infections	Yes/No (If so, how many?)
Change in appetite	Yes/No

Social Situation (e.g. living alone, housebound, occupation?):

Is patient able to attend Out-Patient hospital appointment? (Home visit required)

Functional ability (e.g. please comment on mobility, self care & cognitive ability):

Other agencies involved:

Is the patient being seen under the Mental Health team? Please give details

For domiciliary visiting please detail any risk issues:

REFERRING AGENT
(Please Print and sign):

PROFESSION:

ADDRESS:

CONTACT NUMBER:

DATE:

SAMPLE - DO NOT USE

Please send all referrals to:

Speech and Language Therapy Department,
Ground Floor, Epping Forest Unit, St Margaret's Hospital,
The Plain, Epping CM16 6TN
Tel:
Email:

SAMPLE - DO NOT USE