

**Referral to Adult Outpatient /Community Speech and Language Therapy – Revised July 2019**

**Patient Details:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Hospital number | |  | | | NHS Number | |  | | |
| Surname | |  | | | Forenames | |  | | |
| Date of birth | |  | | | Title | |  | | |
| Address incl post Code | |  | | | Sex/Gender | |  | | |
| Home tel. no. | |  | | |
| Work tel. no. | |  | | |
| Mobile no. | |  | | |
| GP Name | |  | | | GP Practice and address | |  | | |
|  | | Military Service Person | |  | Military Veteran | |  | | Member of Military Family |

**Next of Kin Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| NOK name: |  | NOK relationship: |  |
| NOK Address |  | NOK tel. no. |  |

**Referral Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Referring clinician name |  | Referring clinician role |  |
| Referring clinician’s address  (if different from GP) |  | Referring clinician tel. no. |  |
| Date of referral |  |  | |

***Please note****: Referrals for swallow assessment are accepted from GPs, Community Matrons or Specialist nurses.*

*Patients who have voice problems should be referred to ENT first to check the health of their vocal cords*

**Swallowing**  **Communication**

|  |
| --- |
| **Medical Diagnosis:** |
| **Presenting problem:**  Clinician discussed reason for referral to SLT: Yes No  Patient consent for referral:  Yes No |
| **IMPACT on daily living and Level of RISK from swallow or communication problem:** |
| **Relevant medical history:** Or print and send GP list |
| **Medications:** Or print and send GP list |

**Send an email with this form as an attachment to:** [**shc-tr.speechtherapy@nhs.net**](mailto:shc-tr.speechtherapy@nhs.net) **OR**

**Print and send to Speech and Language Therapy Department, Salisbury District Hospital, SP2 8BJ**