

**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 |  |

**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 [ ] NoPatient 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** **OR**

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