Adult speech and language therapy referral

Please take the time to complete all sections as incomplete referrals will not be accepted

Are you requesting assessment of:		
Swallowing ☐ (complete pages 1, 2 and 3)	Communication ☐ (complete pages 1, 2 and 4)	Both ☐ (complete pages 1, 2, 3 and 4)

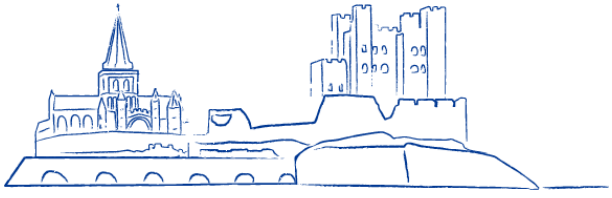
Name: *			
Address: *			
Dob:	*	NHS No:	*
Tel No:	*	Mobile No:	*By giving us your mobile number you consent to receiving SMS reminders of appointments. If you wish to opt out at any time please contact the department.*

GP (Name & Address): *

Consultant:

Medical Conditions (please provides dates of diagnosis/onset of illness if known): *

Medications: *



To what degree does the patient exhibit the following:				
	None	Mild	Moderate	Severe
Recent deterioration in general health *				
Difficulty maintaining seated posture *				
Pain *				
Fatigue *				
Drowsiness *				
Distractability/reduced concentration *				
Challenging behaviours*				
Please outline below any challenging behaviours and how they are currently managed/precautions required (e.g.: two person visits, which direction to approach the patient, etc.)				

Mental capacity and consent to referral

Does patient have capacity to consent to referral to SLT? *	YES	NO
Patient aware of, and agrees to, referral to SLT *	YES	NO
If NO to above is referral being made in patient's best interests? *	YES	NO
Any previous capacity assessments or best interests decisions? *	YES	NO

Name of referrer:	*
Role of referrer:	*
Address for correspondence:	*
Tel no:	*
Signed:	*
Date:	*

We recommend that copies of this referral are a) kept in patient's records and b) sent to patient's GP

Swallowing difficulty

Please indicate to what degree that patient exhibits the following:

	None	**Mild**	**Moderate**	**Severe**
Difficulty maintaining oral hygiene				
Respiratory difficulties, including chest infections				
Difficulty eating/drinking independently/unaided				
Unintentional/unexplained weight loss				
Distress as a result of swallowing difficulty				

Please indicate what type of food/drink the patient is having at the moment:

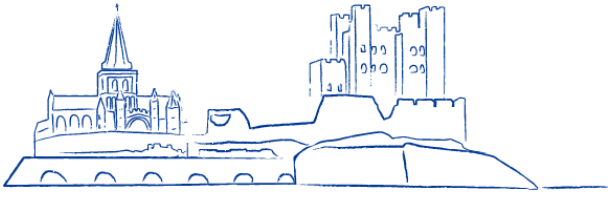
Food:	Unrestricted	Texture E (soft)	Texture D (mashed)	Texture C (thick puree)	Texture B (thin puree)	None / non-oral
Drink:	Normal	Naturally thick	Stage 1 (syrup)	Stage 2 (custard)	Stage 3 (pudding)	None / non-oral
Please describe patient difficulty/symptoms causing concern:						

Is this difficulty:

Long-standing (months/years)	**OR**	Sudden onset (days/weeks)

Is this difficulty:

Regular/predictable (every other day or more?)	
Intermittent/unpredictable (“good days, bad days”)?	
Occasional/infrequent (may have several days, or longer, without difficulty?)	
Any other comments/information:	



Communication difficulty

Please indicate to what degree the patient exhibits the following:

	None	Mild	Moderate	Severe
Difficulty understanding spoken language				
Difficulty using spoken language				
Difficulty understanding written language				
Difficulty using written language				
Slurred speech				
Quiet voice/reduced volume				
Voice changes (e.g.: husky, croaky, strained)				
Stammering/non-fluent speech				
Distress as a result of communication difficulty				
Please describe patient difficulty/symptoms causing concern:				

Is this difficulty:

Long-standing (months/years)	**OR**	Sudden onset (days/weeks)

Is this difficulty:

Regular/predictable (every other day or more?	
Intermittent/unpredictable (“good days, bad days”)?	
Occasional/infrequent (may have several days, or longer, without difficulty?)	
Any other comments/information:	

Please return to: Adult speech and language therapy, Unit 5 Ambley Green, Bailey Drive, Gillingham, Business Park, Kent. ME8 0NJ. 01634 382213 or to adultslt.mch@nhs.net
(A copy of the referral should also be sent to the GP)