**Speech and Language Therapy Referral/Transfer Form – Adult Outpatient Services**

*Please check referral criteria before submitting this form. Please complete the form in full. All inappropriate/incomplete/illegible referrals will be returned to the referrer.*

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| **A: Patient Details**Surname: Forename: Date of Birth: NHS Number:Male/FemaleAddress:Postcode: Telephone: | GP Name:Practice Address:Next of kin/carer details (if relevant):What is the patient’s first language?:Is an interpreter required? **Yes / No** |
| **B: Infection Control**Does the patient have, or recently had: **MRSA / Clostridium Difficile / COVID-19 / Or other communicable infection?** If yes, please give details: ………………………………………………………………………………………… |
| **C: Access / Security*** Can this patient attend an Outpatient or Telehealth Clinic? **Yes / No** *(If yes please circle which one)*
* If a domiciliary visit required, does this patient: **lives alone with no carers / lives alone with a package of care / lives with family or live-in carer / in a Nursing Home / Residential Home ?**
* Are there any safety/security issues? **Yes / No / Don’t know**

If yes, please give details:………………………………………………………………………………………………… |
| **D: Medical and Psychological History** (please attach reports, medical summary, medication list if available): |
| **E: Reason for Referral:** **Communication (speech, language, cognition, voice) ☐ Swallow ☐**Does this patient have capacity to consent to this referral? **Yes / No** Is the patient aware of the referral? **Yes / No** |
| **F: Please complete this box for dysphagia (swallow) referrals:*** What is the concern with the patient’s swallowing? (please describe below)

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 If yes, how often? **Every time they eat/ drink Daily Weekly Less than once a week*** Has the patient had any chest infections in the last 6 months? **Yes / No**

 If yes, please give details………………………………………………………………………………………………* Has the swallowing difficulty had a sudden onset or is it rapidly deteriorating? **Yes / No**
* What are the patient’s current diet and fluid consistencies?

Food: **Level 7 Regular / Level 7 easy to chew / Level 6 soft & bitesize / Level 5 minced & moist / Level 4 puree / Level 3 liquidised / via PEG** **/ no food by mouth**Fluids: **Level 0 thin / Level 1 slightly thick / Level 2 mildly thick / Level 3 moderately thick / Level 4 extremely thick / via PEG / no fluids by mouth*** Does the patient have a Risk Feeding plan in place? **Yes / No**

 If yes, please give details: ……………………………………………....................................................................***Please note that we only accept referrals from Nursing Homes if the GP has been informed and has agreed to the referral. Please tick to confirm:*** [ ]  |
| **G: Please complete this box for communication referrals:*** What is the concern with the patient’s communication? (please describe below)

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* Has the patient seen a speech and language therapist before for this problem? **Yes / No**

If yes, please give details:…………………………………………….................................................................. |
| **H: Referrer Details** Name (please print): Designation:Location/base: Telephone:Signature: Date:  |
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The quickest way to return forms is via email to qvh.salt@nhs.net. Please note that we do not offer a rapid response service. Forms can also be posted to: **Adult Speech and Language Therapy Department (Rehabilitation Unit), Queen Victoria Hospital NHS Foundation Trust, Holtye Road, East Grinstead, West Sussex. RH19 3DZ.**

Enquiries can be made by phoning: **01342 414471,** but referrals will not be accepted by telephone.