**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.*

|  |  |
| --- | --- |
| **A: Patient Details**  Surname: Forename:  Date of Birth: NHS Number:  Male/Female  Address:  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)   ...............................................................................................................................................................................  …………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………   * Does the patient cough or show any other signs of aspiration with eating and drinking? **Yes / No**   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)   .....................................................................................…………………………………………………………….…………………………………………………………………………………………………………………………...  ……………………………………………………………………………………………………………………………   * Is the patient’s communication impairment affecting any of the following: **independent living / ability to work / ability to socialise / ability to make basic needs known ?** * 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: | |
|  | |

The quickest way to return forms is via email to [qvh.salt@nhs.net](mailto: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.