**Speech and Language Therapy Referral/Transfer Form – Community Adult 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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| Surname: Forename:  Date of Birth: Male/Female  Address:  Postcode: Telephone:  NHS Number:  QVH Hospital Number (if known): V | GP Name:  Practice Address:  Is this client under the ongoing care of a Hospital Consultant? Yes/No  If yes, please give details: |
| Are there any safety/security issues? Yes / No / Don’t know  If yes, please give details: | |
| Does the client have, or recently had: MRSA (Yes/No), Clostridium Difficile (Yes/No) or other communicable infection (Yes/No). If yes, please give details: ……………………………………………............ | |
| Can this client attend an Outpatient Clinic? Yes/No Does this client require a Domiciliary Visit? Yes/No  If domiciliary visit required, does this client: live alone with no carers / live alone with carers visiting / live with family or live-in carer / reside in a residential or nursing home.  Next of kin/carer details (if relevant): | |
| Does this client have capacity to consent to this referral? Yes/No Is the client aware of the referral? Yes/No | |
| Diagnosis and relevant medical and psychological history (you may attach reports or medical history print outs, if available): | |
| Reason for referral (please tick): **Communication (speech, language, cognition, voice) ☐ Swallow ☐**  Details, i.e. current speech or swallow problem: | |
| **This box to be completed for Dysphagia (swallow) referrals only:**  Is the client managing adequate hydration? Yes/No  Is the client managing adequate nutrition? Yes/No  Any recent unintentional weight loss? Yes/No  Has the client had any chest infections in the last 12 months? Yes/No  If Yes, please give details:………………………………………………………………………………….  Food: Normal / soft, easy chew or fork mashable / pre-mashed / thick puree / thin puree / via NG / via PEG  Fluids: Normal / slightly thick / stage 1 / stage 2 / stage 3 / via NG / via PEG  Medication: Tablet / Tablets need to be crushed / Tablets are taken in yoghurt, or similar food / suspension form medication | |
| Other services requested/already involved (give details):  Has a referral been made to SLT elsewhere? | Referral is Urgent/Non Urgent  \*Please note that we do not offer a rapid response service  First Language:  Interpreter required? Yes/No  If yes, which language?....................................... |
| **Referrer Details**  Name (please print): Designation:  Location/base: Telephone:  Signature: ………………………………………… Date:  ***Please note that we only accept referrals from Nursing Homes if the GP has been informed of and agreed to the referral. Please tick to confirm:*** | |

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

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.