

**REQUEST FOR ADULT ACQUIRED SPEECH & LANGUAGE THERAPY**

***Please complete this form in full as incomplete referrals will be returned.***

|  |  |
| --- | --- |
| **DATE:** | **This referral has been discussed with the patient and patient consents to the relevant information being shared with the service provider? YES / NO** |
| **SURNAME:** | **FORENAMES:** |
| **DOB:** | **NHS NUMBER:** |
| **ADDRESS (inc postcode):** **POSTCODE:** |
| **TELEPHONE NUMBER: Patient consents to messages being left? YES / NO****MOBILE NUMBER: Patient consents to messages being left? YES / NO** |
| **GP/ Practice:** | **Language:****Interpreter Required? YES / NO** |
| **NEXT OF KIN NAME AND CONTACT NUMBER** |
|  **Is the next of kin aware of referral? YES / NO****TEL: MOBILE:**  |
| **PLEASE CHECK BEFORE MAKING REFERRAL** |
| **DOES THIS PATIENT HAVE LEARNING DISABILTIES?** **- please refer to Learning Disabilities team, LD corridor, Flatts Lane Centre, Flatts Lane, Normanby, Middlesbrough, TS6 0SZ, tel: 01642 283717** **IS THIS PATIENT CURRENTLY UNDER THE CARE OF TEWV MENTAL HEALTH SERVICES FOR OLDER PEOPLE (i.e. Woodside, MHSOP Consultant or CPN etc.) – Please refer to Nutrition and Dysphagia, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS, tel: 01325 552156** |
| **MEDICAL HISTORY** |
|  |
| **CURRENT MEDICATION** |
|  |
| **PART A – REFERRAL FOR SWALLOWING DIFFICULTIES YES / NO** |
| **REASON FOR REFERRAL – Please provide as much detail as possible to help us triage effectively** |
|  |
| **When did the patient start experiencing this difficulty?** |  |
| **How often does the patient have this difficulty?** | **🞏 Every time they eat or drink****🞏 Once a day****🞏 Once a week****🞏 Less than once a week** |
| **Has the patient experienced any weight loss?** | **YES / NO If yes, please state how much:** |
| **Is the patient acutely unwell?** | **YES / NO** |
| **Is the patient appropriate for hospital admission?** | **YES / NO** |
| **Does the patient have an advanced care plan?** | **YES / NO** |
| **Is the patient receiving palliative care?** | **YES / NO** |
| **What diet is the patient currently having to eat?** | **🞏 Level 7 / Normal Diet****🞏 Level 6 (Soft and Bite-sized) / E Diet (Fork-mashable)****🞏 Level 5 (Minced and Moist) / D Diet (Pre-Mashed)****🞏 Level 4 (Pureed Diet) / C Diet (Puree)****🞏 PEG / NG Fed****🞏 NBM** |
| **What fluids is the patient currently having to drink?** | **🞏 Level 0 (Normal fluids)****🞏 Level 1 (Slightly Thick) / (Naturally thick fluids)****🞏 Level 2 (Mildly Thick) / Stage 1 (Syrup thick fluids)****🞏 Level 3 (Moderately Thick) / Stage 2 (Custard thick fluids)****🞏 Level 4 (Extremely Thick) / Stage 3 (Pudding thick fluids)** |
| **Has the patient had recent chest infections? (in the last 12 months)** | **YES / NO If yes, approximately how many?** |
| **PART B – REFERRAL FOR COMMUNICATION DIFFICULTIES YES / NO** |
| **Does the patient have:** **🞏 Difficulty understanding spoken language****🞏 Difficulty expressing information****🞏 Unclear speech****🞏 Dysfluency / stammering****🞏 Voice problems (ENT referral required)****🞏 Other****Please describe the difficulties the patient is having:** |
| **APPROPRIATE VENUE**  |
| **🞏 Outpatient Clinic****🞏 Home Visit (please give reason) ………………………………………………………………………………** |
| **LONE WORKING – Please detail if there are any lone worker issues we should be aware of** |
|  |
| **REFERRER NAME: CONTACT NUMBER:****REFERRER ADDRESS:** |

**PLEASE ENSURE YOU HAVE COMPLETED ALL SECTIONS**

**Please return completed forms to:**

Adult Speech and Language Therapy Department, Rehabilitation Centre, The James Cook University Hospital, Marton Road, Middlesbrough, TS4 3BW **or email to** **ste-tr.salt@nhs.net**

**Adult Speech Therapy contact number: 01642 854497**

***Please note we no longer have access to a fax machine and we no longer accept telephone referrals***