

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

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

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| **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**](mailto: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***