Adult Speech and Language Therapy Referral Form

*Please note **all relevant sections** of this form must be completed. Any referral form not completed with sufficient information may be returned to you.*

Please email completed form to fchc.slt@nhs.net
Any queries please contact 01883 733 891

PLEASE NOTE

SLT at First Community are only comissioned to see patients that are registered with an **East Surrey GP.**

If the patient's primary diagnosis is a **learning disability,** referrals needs to be sent to: Surrey Borders Partnership NHS Foundation Trust, rxx.ctpldeast@nhs.net

SLT at First Community are currently not commissioned to provide a service to adults with a **primary mental health diagnosis** or **with head and neck cancer.**

If the referral is for **dysphonia/voice difficulties**, referrals should be made to: SASH Adult SLT Service, East Surrey Hospital, Canada Avenue, Redhill, Surrey RH1 5RH. Referrals for this service will only be accepted if sent with an ENT Assessment from a SASH Consultant.

Patient Details		**Referrer Details**	
Name		Name	
DOB		Profession/Title	
NHS Number		Contact Address	
Ethnicity		Telephone number	
Home address		Date Referral sent	
Telephone number		GP Name/address (if not referrer)	
Email		Any other Health Professionals involved? E.g., Consultant	
Next of Kin/Relationship Telephone Number			

Please state primary **medical diagnosis** and useful information:

☐ Stable ☐ Improving ☐ Deteriorating ☐ End of life

Medication (or attach list):

Does the patient have Dementia (including Lewy Body Dementia or Primary Progressive Aphasia)? ☐ Yes ☐ No

Does the patient have capacity to consent to this referral? ☐ Yes ☐ No
If yes, are they aware of the referral & have they given their consent ☐ Yes ☐ No
If no, has it been agreed that this referral, & subsequent SLT input, is in the patient's best interests? ☐ Yes ☐ No

Social Situation	Who should we contact to arrange an appointment?
☐ Lives alone ☐ Lives with family ☐ Lives alone with carers visiting ☐ Lives with live-in carer ☐ Residential care ☐ Nursing care ☐ Other Are there any risks that may present to a therapist visiting this patient at home?	☐ Patient ☐ NOK ☐ Care Agency ☐ Other Provide contact details: Can the person attend an outpatient clinic? ☐ Yes ☐ No Can the person access an appointment over video? ☐ Yes ☐ No

Triage

Do you consider this referral to be Urgent? ☐ Yes ☐ No

Is the patient/carer/relative expressing levels of concern/anxiety/distress as a result of their communication or swallowing difficulty? Comments:

Has the person previously had input from a Speech and Language Therapist? ☐ Yes ☐ No

Please provide details:

Swallowing Difficulties

New or existing difficulty? If existing – what has changed?

Please describe the primary concern (For example: food/drink spilling from mouth, choking, coughing, throat clearing, wet voice, chest infections)

What is patient currently eating/drinking?

CURRENT FOOD TEXTURE	CURRENT DRINK CONSISTENCY
☐ Level 7 Regular Diet	☐ Level 0 Thin Fluids
☐ Level 7 Easy to Chew Diet	☐ Level 1 Slightly Thick Fluids
☐ Level 6 Soft & Bite-sized Diet	☐ Level 2 Mildly Thick Fluids
☐ Level 5 Minced & Moist Diet	☐ Level 3 Moderately Thick Fluids
☐ Level 4 Pureed Diet	☐ Level 4 Extremely Thick Fluids
☐ Level 3 Liquidised Diet	

Please answer the following questions before considering a referral to this service:

- If difficulties are only with swallowing tablets, discuss alternatives with GP.
- Are signs of difficulty confirmed to be only after food or drink taken? ☐ Yes ☐ No
- Is assistance needed with food/drink/oral care? ☐ Yes ☐ No
- Do they have a current or suspected chest infection/chestiness now? ☐ Yes ☐ No
- Have they had recurrent chest infections in the last year? ☐ Yes ☐ No
- Is the patient alert enough to have oral intake? ☐ Yes ☐ No
- Is the patient appropriately positioned for oral intake? ☐ Yes ☐ No
- Do they have a diagnosis of oesophageal difficulty? ☐ Yes ☐ No
- Have any medical reasons for difficulty been addressed? ☐ Yes ☐ No
- If the person has reflux/heartburn, has this been treated? ☐ Yes ☐ No
- If intake is reduced, has a MUST assessment been completed, and referral to Dietitian actioned if appropriate? ☐ Yes ☐ No
- Is it anticipated that the person may die in the next 1-2 weeks? ☐ Yes ☐ No

Communication Difficulties

Please describe the communication difficulties and reason for referral:
(For example, understanding, using language, slurred speech, stammering)

New or existing difficulty? If existing – what has changed?

Can the person communicate basic needs / call for help? ☐ Yes ☐ No

Can the person communicate with family/friends? ☐ Yes ☐ No

Social impact of communication difficulties:

Accessible Information Needs (AIS):