**SPEECH & LANGUAGE THERAPY REFERRAL FORM FOR ADULTS**

**Please return this completed form to the Central Booking Office**

**IF ALL PAGES OF THIS FORM ARE NOT FULLY COMPLETED, IT WILL NOT BE PROCESSED AND WILL BE RETURNED TO YOU FOR COMPLETION AND RESUBMISSION**

**By email:** [**CBS.General@uhcw.nhs.uk**](mailto:CBS.General@uhcw.nhs.uk) **Or by post:**

**Patient Access & Booking, Central Booking Office, Wayside House, Wilsons Lane, Coventry, CV6 6NY**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DETAILS OF THE PERSON BEING REFERRED** | | | | | | | | | |
| **First name:** | | **Surname:** | | **Gender:** | | **Date of birth:** | | | |
| **NHS Number:** | | **Ethnic origin:** | | **Language(s) spoken:** | | **Do they need an interpreter?**  Y  N | | | |
| **Full address**:  **Post Code**: | | | | | | | |
| **Telephone number (landline):** | | | **Mobile telephone number:** | | | | |
| **Primary Contact:**  **Relationship to patient:** | | | **Is this person clinically housebound?**   * Yes * No | | | | |
| **Has the person consented to the appointment?**   * Yes * No * Unable to Consent | | | **IS THIS PERSON ON AN END OF LIFE PATHWAY?**   * Yes * No | | | | |
| **Medical history: Please tick**  CVA (stroke)  Date(s) of CVA(s):  COPD  Dementia  Epilepsy  Head injury  Huntington’s Disease  MND /  Multiple Sclerosis  Parkinson’s Disease  Other: | | | **THE PERSON YOU ARE REFERRING MUST HAVE A COVENTRY GP**  **Name of GP:**  **Address:**  **Telephone number:** | | | | |
| **Are any other health professionals involved?**  **Please tick:**  Physiotherapy  Psychology  Occupational Therapy  Dietician  Community Neuro- Rehabilitation Team  PD Nurses  COPD Team  Other: | | | **Other information you feel is important for us to know**  **E.g - risk issues** | | | | |
| **REFERRER’S DETAILS** | | | | | | | |
| **Name of the person making this referral:** | | | | **Position/title:** | | | |
| **Address for correspondence**: | | | | **Telephone number:** | | | |
| **Referrer’s Signature:** | | | | **Date:** | | | |
| **Please complete the questions below**  **Please give as much information as you can Thank you** | | | | | | | |
|  | | | | | | | |
|  | | | **Comments/details** | | | |  |
| Does the person cough or choke regularly when eating and/or drinking?   * Yes * No | | | Eg How often? On food/drinks/both? | | | |  |
| **Have you noticed the following occurring on a DAILY basis?**  Swallowing seems effortful? ­­­­­­­­­­­­­  Refusing and/or spitting out food and/or drink?  Food or drink falling out of the mouth?  Person needs more than 2 swallows for each mouthful?  Meal times are taking longer?  Wet or gurgly sounding voice after swallowing  Pain or discomfort when swallowing  Difficulty breathing after swallowing  Food or drink coming out of the nose or mouth  Food or drink remnants in the mouth after swallowing  Holding food and/or drink in the mouth  Cramming food in the mouth | | |  | | | |  |
| Does this person have a history of chest infections?   * Yes * No   How many in the last 12 months?  ­­­­­­­­­­­  Have these chest infections resulted in hospital admission/s?   * Yes * No | | |  | | | |  |
| What fluid consistency is this person currently having?  IDDSI  Level 1  Level 2  Level 3  Level 4  Not Sure  Normal  Stage 1  Stage 2  Stage 3 | | |  | | | |  |
| What diet consistency is this person currently having?  Level 4 Puree  Level 5 Minced and Moist  Level 6 Soft and Bite Sized  Level 7 Easy to Chew  Level 7 Regular/Normal  Does the patient have bread?   * Yes * No | | | What is difficult for them to eat? | | | |  |
| Has the patient experienced any unplanned weight loss?   * Yes * No | | | How much weight have they lost?  Over what period? | | | |  |
| Does this person need help with eating and drinking?   * Yes * No | | |  | | | |  |
| Does this person have difficulties taking tablets?   * Yes * No | | | If yes, discuss alternatives with patients GP | | | |  |
| **Voice**  Does the person have problems with their **voice?**   * Yes * No | | | **If yes, referral must be made by ENT, or the ENT clinic letter requesting SLT input be sent with this referral**  **In order to accept the referral, the patient must have seen ENT in the last 6 months** | | | |  |
| **Stammer/stutter**  Does the person have a **stammer/stutter**?   * Yes * No | | |  | | | |  |
| **Language**  Does the person struggle to:  Find the right words to say or write down?  understand what people say to them? | | |  | | | |  |
| **Speech/ speaking**  Does the person have problems with:  Speaking Clearly?  Speaking loudly enough for people to hear? | | |  | | | |  |
| Does the difficulty impact on their/your ability to work?   * Yes * No   If yes, how? | | | What is the person’s job / role? | | | |  |
| Has there been a rapid change in their speech and /or language recently?   * Yes * No | | |  | | | |  |