First Community Health and Care

EMIS ADULT SPEECH & LANGUAGE THERAPY REFERRAL FORM

Please email completed form to fchc.slt@nhs.net Any queries please contact 01883 733 891		***Completion of both pages is compulsory.*** ***Please see overleaf for important referral criteria.***	
Name		NHS Number	
DOB		Ethnicity	
Home address		Next of Kin/ Telephone Number	
Home phone number		Mobile phone number	
Email		Is the patient working?	
Does the patient live alone?		Occupation	

Do you consider this referral to be Urgent?	Yes	No
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

Medical diagnosis & reason for referral:

Current swallowing difficulties:

New or existing? (If existing, what has changed)?

Current communication difficulties (understanding, using language, slurred speech, stammering, other)?

New or existing? (If existing, what has changed)?

What is the patient currently eating/drinking? (please circle)

Food-Regular, Soft & bite-sized (IDDSI Level 6), Minced & Moist (IDDSI Level 5), Puree (IDDSI Level 4)

Drinks – Thin Fluids, IDDSI Level 1, IDDSI Level 2, IDDSI Level 3, IDDSI Level 4

Is the patient/carer/relative expressing levels of concern/anxiety/distress as a result of their communication or swallowing difficulty? High level Moderate level Low level

Any further information of relevance?

Accessible Information Needs (AIS):

Referred by:	Professional Title:
Contact Address:	Telephone No:
GP Name:	Practice: Date:

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

• Is difficulty only with swallowing tablets – if so, discuss alternatives with GP?	Yes	No
• Are signs of difficulty confirmed to be only after food or drink taken?	Yes	No
• Is the patient alert enough to have oral intake?	Yes	No
• Is the patient appropriately positioned for oral intake?	Yes	No
• Have any medical reasons for difficulty been addressed?	Yes	No
• Have any reflux/heartburn issues been treated?	Yes	No
• If intake is reduced, has a MUST assessment been completed, and referral to Dietitian actioned if appropriate?	Yes	No

PLEASE NOTE

If the patient's primary diagnosis is a **learning disability,** referrals needs to be made to:
Surrey Borders Partnership NHS Foundation Trust, Gatton Place, St. Matthews Road, Redhill, Surrey, RH1 1TA.

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

SLT at FCH&C is currently not commissioned to provide a service to adults with a **primary mental health diagnosis.**

SLT at FCH&C is currently not commissioned to provide a service to adults **with head and neck cancer.**

If you have any suggestions or changes to this document please contact fchc.slt@nhs.net