You matter most

PRIVATE & CONFIDENTIAL

NHS
Harrogate and District
NHS Foundation Trust

Adult Speech & Language Therapy
Hambleton Wing
Friarage Hospital
Northallerton
North Yorkshire, DL6 1JG
Tel: 01423 542330

E-mail: HDFT.ADULT-SLT@nhs.net

ADULT SPEECH AND LANGUAGE THERAPY REFERRAL

Incomplete referrals will be returned to the referrer
Please type / write into highlighted boxes &
E-mail or post to the address above

Name:		**DOB:**	
		NHS No:	
Address:		**GP / Surgery:**	
Contact No:		Has the GP agreed to this referral?	YES / NO (please delete)
Is the patient aware of the referral? YES / NO (please delete) (if no, please comment why)		Are they able to travel to an appointment? YES / NO (please delete) (if no, please comment why)	
Previous Medical History		**Current Medication**	

Part 1: Swallowing Difficulties

Please give a brief description of the problem:

Are they taking anything orally:

What is their position like when eating and drinking:

What texture does the person normally manage? FOOD FLUID

Please describe their dentition:

What happens when they have **food**?

- ☐ Coughing / choking
- ☐ Wet voice
- ☐ Eye glaze
- ☐ Pouching
- ☐ Other

What happens when they have a **drink**?

- ☐ Coughing / choking
- ☐ Wet voice
- ☐ Eye glaze
- ☐ Pouching
- ☐ Other

Other signs of aspiration:

- ☐ Recurrent chest infections
- ☐ Rapid weight loss

Date of last chest infection (mm / yy) /

Current weight

Have you tried making any changes to diet / fluids? ☐ YES ☐ NO

If yes, what and how effective has it been?

Part 2: Communication Difficulties

Please give a brief description of the problem:

Do they have difficulties with any of the following;

- ☐ Understanding what is being said
- ☐ Expressing their needs
- ☐ Finding the right word
- ☐ Understanding what they read
- ☐ Writing
- ☐ Cognition (memory, judgement, problem solving, planning, perception

Do they wear glasses ☐ YES ☐ NO distance / reading? _____

Do they wear hearing aids? ☐ YES ☐ NO one / both ears? _____

Is the person able to communicate? YES / NO If so, how? (Please delete)

Any other information:

Other Professionals involved:

Name of Referrer: _____ **Signature:** _____

Designation: _____ **Date:** _____

Full Address: _____

_____

Contact Number: _____

Office use only – triage

ACTION:

- Voice Group ☐
- Voice 1:1 ☐
- Communication ☐
- Mental Health ☐

Additional Comments: (Please detail below)

Primary:

Secondary:

Dysphagia

Low ☐ **Med** ☐ **High** ☐

Date Received: _____

Triage By: _____