**HALTON ADULT SPEECH & LANGUAGE THERAPY REFERRAL FORM**

**REASON FOR REFERRAL**

Communication  Swallow  Both

***What can we help you with?***

***What have you already tried?***

***How motivated is the patient to engage? (on a scale from 1 – 10)***

1 2 3 4 5 6 7 8 9 10

(not) (highly

motivated) motivated)

**Please explain:**

***How is this problem affecting this person’s life? (on a scale from 1 – 10)***

1 2 3 4 5 6 7 8 9 10

(Very minimal (Major impact)

**Please explain:**

**PATIENT’S DETAILS**

|  |  |
| --- | --- |
| Name: | D.O.B.: |
| Ethnicity: | NHS Number: |
| Email Address: | N.O.K.: |
| Current Address/Location: | |
| Telephone No: (who do we contact to discuss the patient: (name/number/relationship) | |
| Occupational Status: | Carers Responsibility: Yes  No |

***DIAGNOSIS***: (i.e., PD, MND, MS, Stroke, HD, Frailty, Dementia, FND, MSA)

***Relevant Medical History, relevant medications***: (i.e., chest status, weight loss, allergies, cognitive changes)

Does the patient have a learning disability?  Yes  No

**Risk Assessment** (in relation to the patient or anyone within their household)

Joint Visit Required:  Yes  No

Details (if ‘Yes’) – i.e., safety concerns to therapist/patient/other:

***Types of appointments patient able to access:***

Virtual Appointment  Telephone Appointment  Home Visit  Out Patient Clinic

***Relevant Social Information:***

Lives alone with no social services input  Lives with spouse/family

Lives alone with package of care  Other

**REFERRER’S DETAILS:**

|  |  |
| --- | --- |
| Name: | Job Title: |

Address:

Telephone Number/Practice:

***INCOMPLETE FORMS WILL BE RETURNED***

***Email to:*** [***BCHFT.HaltonSpeech@nhs.net***](mailto:BCHFT.HaltonSpeech@nhs.net) ***Phone: 01928 593765 – a duty therapist will be available Mon-Fri to discuss any referral queries***