**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*** ***Phone: 01928 593765 – a duty therapist will be available Mon-Fri to discuss any referral queries***