

## **Speech and Language Referral Form**

Email referrals - integratedhub@berkshire.nhs.uk

All fields need to be completed in order for the referral to be accepted.

Name of client: Date of birth:	NHS Number:	Referral Date:		
Has client consented to service:	Name of person making referral:			
Yes □ No □	Traine or person maring resonant			
Client's ethnicity:	Job title, Department, Address:			
Client's main language:				
Client's main language: Interpreter needed? Yes □ No □	Contact telephone number:			
Client's Address:	Email address:			
Client's Address.				
Postcode:				
Telephone Number/s:				
Please provide an email contact, as Adult Speech and Language Therapy now offer telehealth appointments as first appointment.				
Email address:				
Client consented to be sent information via email? Yes \( \square \) No \( \square \)				
Will client have support for online /telephone appointment Yes □ No □				
If unable to access please provide reasons and detail below:				
GP Name, address, telephone, email:	Next of kin:			
Ci Mario, addreso, telepriorio, email.	Relationship:			
	Contact no.:			
	Carer information:			
All face-to-face appointments will be held in	clinic unless client is bedbound o	or housebound.		
Is the client bedbound/housebound (this should be documented in the GP summary)? Yes $\square$ No $\square$				
Does client have a keysafe? Yes □ No □				
Communication requirements?				
·				
Unable to use the phone ☐ Hard of hearing ☐ Unable to read ☐ Other (please specify)				
Wedical Conditions				
Please attach any recent relevant reports from consultants/investigations relating to the client's				
condition e.g. neurologists, videofluoroscopy, gastroenterologist/barium swallow, ENT				



Medication				
Referral for: Swallowing   Communication   Please state reason for referral and goal of assessment/therapy:				
Client Name:	NHS Number:			
For communication referrals only: Sudden onset  Gradual decline				
Current difficulties:				
☐ Difficulty producing words or connected speech / word finding difficulties				
<ul> <li>□ Difficulty comprehending / understanding language / following instructions</li> <li>□ ↓ Voice quality e.g.: hoarse, breathy, soft.</li> </ul>				
N.B if client is being referred for specific voice difficulties, they must have had a recent ENT assessment (within 6 months). Please attach report.				
Please note - we do not accept referrals for dysfluency, hearing loss, developmental dyslexia, dyspraxia, dyscalculia, accent modification and these referrals will be returned.				



For swallowing referrals only: Sudden onset □ Gradual decline □				
Current recommendations / oral intake: Oral intake  Diet:	Fluids:	PEG □		
Level 7, Regular	☐ Level 0, Thin			
Level 7 Regular; Easy-to-chew	☐ Level 1, Slightly Thick			
Level 6, Soft & Bite-sized	☐ Level 2, Mildly Thick			
Level 5, Minced & Moist	Level 3, Moderately Thick			
Level 4, Puree	☐ Level 4, Extremely Thick			
☐ Level 3, Liquidised				
Please refer to IDDSI framework if unsure - www.iddsi.org				
Signs of aspiration:  Coughing on foods Occasionally (1-3 times per week)	□ Once a day □	Every meal		
Coughing on fluids Occasionally (1-3 times per week)	☐ Once a day ☐	Every drink $\square$		
Recurrent, unexplained chest infections Yes $\square$ No $\square$				
<b>Choking episodes on food:</b> Partial or complete obstruction of the airway that may have required back slaps or abdominal thrusts and possible hospitalisation Yes $\square$ No $\square$				
Other eating and drinking difficulties:  □ Drooling □ Difficulty keeping food in mouth □ Holding food in mouth	☐ Effortful Chewing ☐ Sensation of foo ☐ Other	d sticking in throat		

Thank you for completing this referral. Please ensure all the necessary details have been submitted as this helps us to triage appropriately.