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**OFFICE USE ONLY**: Date received:  
Database checked?:

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| **Date** |  | **ADULT NEUROLOGY SPEECH AND LANGUAGE THERAPY -  COMMUNITY REFERRAL FORM** | | | | | | |
| **Patient Details** | **Name:** |  | **Date of Birth:** | |  | **Gender:** | |  |
| **NHS Number:** |  | **Ethnicity:** | |  | | | |
| **Address:** | **Postcode:** | | | | | | |
| **Tel Number(s):** |  | | | | | | |
| **Who to contact for appointment:** | Patient: □ Care Home Staff: □ Next of Kin (please specify): □ Other (please specify): □ | | | | | | |
| **GP Details:** | GP (Doctors) Name:  GP Practice (Address): | | | | | | |
| **Referrer Details** | **Name & Profession:** |  | | **Telephone/Email:** | | |  | |
| **Contact Address & Postcode:** (If different from above) |  | | | | | | |
| **If referring on behalf of someone: is the patient aware of the referral? Yes / No** | | | | | | | | |
| **Is the patient on the Learning Disability Register? Yes / No**  *If Yes, please note we do not routinely see patients with Learning Disability. Please contact the Community Team for Learning Disability(CTLD) - ask if known to CTLD Speech Therapists and refer to them. Tel: 0191 2106868* | | | | | | | | |
| **Is an interpreter required? (if so which language):** | | | | | | | | |
| **Relevant Medical History (current diagnosis) :** | | | | | | | | |
| **Any previous SLT Involvement? :** | | | | | | | | |

***If you are referring due to swallowing problems, please complete section A. For communication problems, please complete section B.***

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| **SECTION A - Swallowing** |
| **Please ensure resident has been carefully observed at meal and drink times and the issues recorded below are accurate. We need to understand the frequency and severity of the problem. We cannot process the referral if this has not been completed.** |
| What are your/ the residents current **diet and fluid recommendations**? |
| **Please describe…**  …what is happening?  …How often?  …How long has the problem been happening? |

**SECTION B - Communication**

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| If you are referring **due to difficulties with their speech/communication**, please describe the problem below: |

Please help save paper and protect patient confidentiality– do not send full patient summaries if input is not relevant to Speech Therapy or the presenting issues.

PLEASE RETURN COMPLETED REFERRAL FORMS TO:

EMAIL: [tnu-tr.adultcommunityslt@nhs.net](mailto:tnu-tr.adultcommunityslt@nhs.net) (preferred)

POST: Community Speech and Language Therapy, Denton Park Health Centre, West Denton Way, Newcastle upon Tyne, NE5 2QW.

For any other queries please phone: 0191 2138841.