Rotherham Doncaster and South Humber NHS Foundation Trust

Speech and Language Therapy: Adult Community Team Referral
(GP/Consultant or Community Nurse/AHP)
Please ensure the person has consented to the referral or has been completed in their best interests.

Patient Name:	Patient Address:
NHS Number:	Patient Telephone:
Date of Birth:	Relevant Contacts:
Email address:	

Primary Diagnosis:	Past Medical History:
Medications:	GP Practice:

Location (tick as appropriate): ☐Own home – able to attend clinic ☐Own home – housebound ☐Inpatient ward (Tickhill Road Site) Please note, all swallowing referrals for care home residents should be completed by care home staff.	Reason for referral (tick as appropriate): ☐Swallowing ☐Communication

Referrals for Swallowing

Symptoms experienced during eating or drinking (tick as appropriate): ☐Coughing ☐Choking ☐Chest infections/deterioration in chest status ☐Wet/gurgly voice quality ☐Shortness of breath ☐Increased/spiking temperature. Other: ☐Weight loss Sensation of food sticking (tick as appropriate): ☐Mouth ☐Throat ☐Upper chest Please refer any issues of swallowing medication to the person's GP or pharmacist.	Current fluid intake (tick as appropriate): ☐Thin fluids (Level 0) ☐Slightly thick fluids (Level 1) ☐Mildly thick fluids (Level 2) ☐Moderately thick fluids (Level 3) ☐Extremely thick fluids (Level 4) Current diet intake (tick as appropriate): ☐Regular diet (Level 7) ☐Regular diet easy to chew (Level 7 easy to chew) ☐Soft and bite sized diet (Level 6) ☐Minced and moist diet (Level 5) ☐Pureed diet (Level 4)

Any other relevant information:

Referrals for Communication

Difficulties experienced (tick as appropriate):	If the referral is for mental capacity assessment support please provide details on the decision, the decision maker, deadlines, and relevant contact details:
☐Slurred speech ☐Difficult finding or thinking of words ☐Difficulty expressing ones self ☐Difficulty understanding ☐Difficulty reading ☐Difficulty writing ☐Quiet voice ☐Change voice ☐Stammering ☐Other (give details):	

When did the problem start?
How did the problem start?
Please details the aim / goal hoping to be achieved by the individual:

All Referrals

Referrer Name:	Referral Job Role:	Referrer Contact Details:	Date:

Please email completed form to doncaster.spa@nhs.net or post:

Speech and Language Therapy Services
Neuroservices Building
Tickhill Road Site
Balby
Doncaster
DN4 8QN
Telephone: 03000 218996

For patients with registered LD please email to: rdash.adultldservices@nhs.net