**Community Adult Speech and Language Therapy**

**Referral Form**

**Please note that we cannot help clients with:**

* Vomiting and sickness unrelated to dysphagia. Please refer on to GP.
* Problems with taking tablets only. Please consult Pharmacist.
* Problems with small appetite or refusing to eat and drink. Please consult Dietician.
* Problems with tube feeding or patients who require reinsertion of a feeding tube. Please refer to GP or Gastrostomy Nurse.

Priority (to be completed by SLT Team)

Date of referral

Patient consent Yes No/Best Interest

**Referral will not be accepted without consent**

P3

P2

P1

Name: ……………………………………… Date of Birth: …………………………….

Address: …………………………………………………………………………………………

……………………………………………………………………………………………………….

NHS No: ………………………………… Telephone No: ……………………………..

Name of G.P …………………………………………………………………………………..

Address: ……………………………………………………………………………………….

Name of referrer

Background medical information (Please attach patient summary if appropriate)

Reason for referral

Please email Referral form to:- **ndht.sltcommunityreferrals@nhs.net**