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Adult Speech and Language Service

Professional Referral Form for Communication

Date of referral……………………………………….

Any sections marked with an asterisk (\*) are mandatory. If they are not complete, the form will not be processed and will be returned to the referrer.

*Tick a minimum of one of the following boxes:*

\* The patient has consented to the referral.

Or

The patient lacks capacity and this referral is being made in their best interests:

Fully review the exclusion criteria below before completing the form.

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| PATIENT DETAILS  \*Name: \*Patient telephone number:  \*Date of Birth: NHS Number:  \***Patient Address and Post Code:** \***Registered GP Practice:**  **Email Address (if available):**  **Interpreter Required: Yes  Language: Preferred Interpreter Gender:**  **Does the patient need help with appointment** e.g. wheelchair access, literacy, learning or mental health needs**:**  **Yes  Please give details:**  **Is the patient considered to be in the last weeks/days of life? Yes  No** |
| \*REFERRED BYName: Designation: Service: Tel. No.: |
| EXCLUSION CRITERIA **The service is unable to accept referrals for individuals:**   * under 18 or without a Barnsley GP. * who are currently hospital inpatients *- contact the relevant inpatient service.* * whose difficulties are the result of a learning disability / autism *- contact the Barnsley Adult Learning Disability Health Service.* * whose difficulties result from a stroke within the last 6 months *- contact Barnsley Community Stroke Rehabilitation Team.* * whose difficulties relates to ENT e.g. head and neck cancer, voice problems, vocal nodules, tracheostomy - *contact ENT services at Barnsley Hospital NHS Foundation Trust via their GP.* * if the referral is for communication difficulties relating to a traumatic brain injury *contact the Barnsley Community Brain Injury Rehabilitation Team.* * if the patient or carer / partner is unable to commit to attending appointments and practising therapy homework in-between appointments. |

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| \***REASON FOR REFERRAL**  *(please tick a minimum of one of the boxes listed for the reason for referral, failure to specify will result in the referral being rejected):*  Expressive communication difficulty e.g. difficulty finding the right words, using the wrong words,  difficulty expressing wants or needs  Receptive communication e.g. difficulty understanding words, sentences, conversations  Alternative and Augmentative Communication (AAC) e.g. using or may require a communication book or  technical device to help support their communication  Speech e.g. dysarthria, speech may be slurred or quiet  Cognitive communication disorder e.g. difficulties staying on topic, planning what they want to say, paying  attention and/or following complex discussion, losing train of thought when talking  Communication partner training e.g. training to carers / family / friends how to better support someone with  changes to their communication  Voice banking  Stammering  Developmental Language Disorder  Other (please specify information relevant to communication referral) ……………………………………………….. |
| **SAFEGUARDING AND SAFETY CONCERNS including PREVENT:**  **a) Are there any known safeguarding risks:  Yes  None Known**  **If yes, tell us who will provide more information:**  **Name: Contact Details:**  **b) Are there any known safety risks?  Yes  None Known**  E.g. infectious conditions, such as cytomegalovirus (CMV), hepatitis, rubella, shingles, measles, Methicillin-resistant Staphylococcus aureus (MRSA), animals and pets, smoking and vaping in the home or risk of violence and aggression (including weapons in the home).  **If yes, please tell us who will provide more information:**  **Name: Contact Details:** |
| **MEDICATION *(Please include details of any prescribed nutritional supplements):*** |
| **MEDICAL HISTORY**  Does the Patient have any of the following (tick all that apply):   |  |  | | --- | --- | | Respiratory (Specify and give details in box below) |  | | Dementia |  | | Cancer (Specify and give details in box below) |  | | Stroke |  | | Motor Neurone Disease (MND) |  | | Progressive Supranuclear Palsy (PSP) |  | | Multi Systems Atrophy (MSA) |  | | Parkinson’s Disease |  | | Huntington’s Disease |  | | Multiple Sclerosis (MS) |  | | Frailty |  | | Heart Condition |  | | Brain Injury |  | | Reflux |  | | Other (Specify and give details) |  | |