

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 BY  Name: 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):

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| 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) | **[ ]**  |

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