Rec'd: *Tri'd:* *Sw / Com / Voi / Stam / Dem: 1 / 2 / 3* *See by:*

Suffolk Community Healthcare

NHS

ADULT (18+) COMMUNITY SPEECH & LANGUAGE THERAPY REFERRAL

Incomplete referrals cannot be prioritised and will be returned to the referrer

Full name: Mr / Mrs / Ms

Address:	**Ethnicity:**

Postcode:	**Telephone:**
DOB:	**NHS number:**

Medical history:

Dementia: yes / no

GP:

Mobility:	**Housing:**
Social situation: *lives alone: yes / no*	**Family/carer contact:**

Swallowing:

Current fluids: *PEG / thin / thick: stage 1 / 2* *(please circle)*

Current diet: *PEG / puree / soft / normal* *(please circle)*

Comments/observations:

- *Coughing on drinking* ☐
- *Holding in mouth* ☐
- *Losing from mouth* ☐
- *Problems chewing* ☐
- *Feeling food sticking* ☐
- *Coughing on eating* ☐

Communication

Current: *speech / gesture /writing / device* *(please circle)*

Comments/observations:

- *Difficulty understanding* ☐
- *Difficulty expressing self* ☐
- *Slurring words* ☐
- *Voice hoarse/quiet* ☐ *(ENT referral may be required)*
- *Stammering:* ☐

Recurrent chest infections:	Cognitive status:
Acute weight loss:	Occupation:

Anxiety / distress / vulnerability:

Further information:

Referrer's name:	**Profession:**
Address:	**Telephone:**
	Date:

***Fax to: 01473 275246* (confidential line)**

Or send to: Adult Speech and Language Therapy Community Service, Allington Clinic, 427 Woodbridge Road, Ipswich, IP4 4ER