Speech and Language Therapy Referral Form

For details of where to send this form: see page 36 of the Manual for Mealtimes

NHS Lothian

Name of Client	**CHI No. or date of birth**
Address	**Medical diagnosis**
	GP
Telephone Number	**Practice**
Next of Kin/Contact	**Relationship**
Social situation	

Name of Referrer	**Address**
Designation	
Telephone Number	**Secure Email**

Why are you referring the person to SLT?	**Swallowing** ☐	**Communication** ☐
Has the client or their proxy consented to this referral?	Yes ☐	No ☐
Is this a new difficulty?	Yes ☐	No ☐
When did it start?		
Note any recent change of medication		
Describe the problem		
Are problem chart and trial of changes sheets attached? Yes ☐ No, meets criteria for immediate referral ☐		
If the person is already known to SLT: Have abilities changed significantly since the last SLT contact? Yes ☐ No ☐ Comments:		

FOR ISSUES WITH SWALLOWING ONLY			
What diet/fluid consistency is the person currently taking?			
What assistance does the person have with eating and drinking?			
Is there coughing or choking during eating or drinking?	No ☐	Occasional ☐	Frequent ☐
Is the voice wet/gurgly during or immediately after eating/drinking?	No ☐	Occasional ☐	Frequent ☐
Have there been any recent chest infections?	No ☐	Occasional ☐	Frequent ☐
Have there been any recent urinary tract infections?	No ☐	Occasional ☐	Frequent ☐
Is the person losing weight?	Yes ☐	No ☐	
Has the person been referred to a dietitian?	Yes ☐	No ☐	

DATE COMPLETED _____ **SIGN** _____

Authorised: Jul 2020
Review: Jul 2023