**Adult Speech & Language Therapy Referral Form**

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| **Please go to the Remedy website using** [Speech & Language (Remedy BNSSG ICB)](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fremedy.bnssg.icb.nhs.uk%2Fadults%2Fspeech-language%2F&data=05%7C01%7Cjane.mcinally1%40nhs.net%7C616d4391bcf7450e8e8108db9d9c6e7f%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638277067406080846%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=qZ5AxS6D1hwg%2Bu9BCo7Vrxl4jH2EVHoCllvjCfJbz9g%3D&reserved=0) **to determine which service the referral should be sent to.** |
| **LOCATION:** South Glos. [ ]  Bristol NBT Catchment [ ] Bristol UHBW Catchment [ ]  North Somerset [ ]   | **Multidisciplinary needs:** Yes [ ]  No [ ]    |
| **Home visit** [ ]   **Outpatient** [ ]   |

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| **Patient Name:** | **Address:****Postcode:****Telephone number:****Email:** |
| **Date of birth:** |
| **NHS Number:** |
| **Next of kin:** | GP and Surgery: Telephone number: |

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| **Reason for referral:** |
| **Swallow**  🞏 | NBM or risk of NBM [ ]  Swallowing with difficulty [ ] Choking with solids [ ]  Coughing with solids [ ] Coughing with fluids [ ]  Repeated chest infections [ ] Weight loss [ ] If choking, please detail intervention required (e.g. back slaps, abdominal thrusts, hospital admission): |
| Current dietary status | Oral [ ]  NGT [ ] PEG/RIG [ ]  Subcut/IV [ ]  |
| **Communication** [ ]  | Difficulties understanding [ ]  Difficulties speaking [ ]  |
| **Outcome sought by referrer (include patient goals if known**): ***This section requires completion*** |
| **Relevant medical history and medication:** (on separate sheet if more space needed. GP history can be attached): |
| **STOP CHECK**Has the patient consented or is referral in best interests? **Yes** [ ]  **No**[ ] Are there any known risks with lone/ home visits? **Yes** [ ]  **No**[ ] **Details**: Hospital Transport **Yes**[ ]  **No**[ ] Needs interpreter **Yes**[ ]  **No**[ ]  |
| Referrer name (print):  | Role:  | Date of referral:  |
| Referrer address: Phone number: Email:  |