**Outpatient Referral to**

**Adult Speech & Language**

**Therapy Service**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Date**: / / | | | | | | | | |
| \* | **Patient Details**:  **Surname**: | |  | | **Referrer Name**  **& Designation**: | | |  | |
| \* | **Forename:** | |  | | **Referrer’s Address:** | | |  | |
| \* | **Email address:** | |  | |
| \* | **Address:** | |  | | **Referrer telephone No:** | | |  | |
| **GP:**  **Address:** | | |  | |
| \* | **Postcode:** | |  | |
|  | **Home phone number:**  **Daytime phone number:**  **Mobile number:** | |  | | **Postcode:** | | |  | |
| **Phone number:** | | |  | |
| \* | **Date of Birth:** | |  | | **Nursing Home** | |  | **Residential Home** |  |
| \* | **NHS number:** | |  | | **MRN number:** | | |  | |
|  | **Current Medical Problem** – Printout Can Be Attached | | | | | | | | |
|  | **Past Medical History, To Include Previous SLT Referrals** – Printout Can Be Attached. *As appropriate* | | | | | | | | |
| \* | **Reason for Referral –** Please give as much information as possible (please note for a voice problem an ENT opinion will be required prior to therapy) | | | | | | | | |
|  | **Current Medication Printout can be attached if available** | | | | | | | | |
|  | **Is a home visit required Y/N** | | |  | | | | | |
|  | **Priority:-** | **Urgent** | |  | | **Routine** | | | |
|  | **Please note:- If the patient has a voice problem, please refer to ENT initially.** | | | | | | | | |

Please post or fax this completed form to:

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| --- | --- | --- |
| **Adult Speech & Language Therapy Department**  **Gloucester Royal Hospital**  **Great Western Road**  **Gloucester**  **Gloucestershire**  **GL1 3NN** |  |  |
| Tel: 03004 228105  Fax: 0300421 6862 |  |  |

**Please note**: Incomplete forms or other forms of referral may be returned. **Please only use this form**.