**Outpatient Referral to**

 **Adult Speech & Language**

 **Therapy Service**

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|  | **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**.