###### Speech & Language Therapy in Mental Health

##### Community Referral Form

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| **Name: Sex: M / F / Other DOB:**    **Address:**  **Telephone no:**  **Is it appropriate to contact the person? YES / NO\***  **Interpreter required? YES / NO**  **\*If NO, Name & Telephone no. of key contact:**  **Person given consent to referral? YES / NO\***  **\*If NO, why?**  **Person given consent to information sharing? YES / NO**  **If NO, why?** | | | | | | |
| **Consultant:**  **GP details:** | | | | | **Community team:** | |
| **Reason for referral:**  **Please note, the referral may not be processed if this section is not completed**  **SWALLOWING PROBLEMS:** Please tick (as many as apply)  Difficulty biting or chewing food  Eating too quickly or too slowly-state which  Spitting out food, drink, tablets  Holding food or drink in the mouth without swallowing  Coughing when eating or drinking  Refusing to eat or drink with no obvious reason  A choking episode (give brief details)  Other (give brief details)  Does the person have a history of the following? Please tick  Frequent chest infections/pneumonia  Unexplained weight loss  **COMMUNICATION:** Please describe the problem and what you / the client wishes to achieve from SLT intervention | | | | | | |
| **Psychiatric & medical history:** | | | | | | |
| **Social history: i.e. significant other(s), current living arrangements etc** | | | | | | |
| **Please complete in full to ensure the referral is processed**  **Risk Assessment Information:**  1. Please detail all known risks: Suicide/ self-harm ❑ Not considered risk ❑  Harm to others ❑ Self-neglect ❑  Harm from others ❑  Other (including forensic history) ❑ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  2. What safety factors need to be considered for the therapist working alone? (e.g. safety of access etc.)  3. Please give details of any warning signs indicating deterioration in mental state:  4. Please indicate who would be most appropriate person to participate in ongoing liaison regarding  Speech & Language Therapy input (if different from the referrer):    Name: Position: Contact details: | | | | | | |
| **Other agencies involved:**  Recovery Centre / Day Centre:  Social Worker/ Care manager:  Psychologist:  Occupational Therapist:  Physiotherapist:  Dietician:  Other eg voluntary services etc: | **YES**  ❒  ❒  ❒  ❒  ❒  ❒  ❒ | **NO**  ❒  ❒  ❒  ❒  ❒  ❒  ❒ | | | **Contact details**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **Other Information:**  Does the client have regular CPA reviews? **YES / NO** Next review due:\_\_\_\_\_\_\_\_\_\_  Does the client have any visual or hearing difficulties? **YES / NO** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\*\*\* Please enclose a copy of a relevant reports e.g. medical, psychiatric, etc**  **or provide title of report from Carenotes\*\*\*** | | | | | | |
| **Referrer details:**  **Name:**  **Job title:**  **Address:** | | | **Date:**  **Tel number:**  **Signature:** | | | |

**Please return to:**

Speech and Language Therapy MH, Goodinge Health Centre, 20 North Rd, Islington N7 9EW

*Direct line: 020 3316 8520* ***email:*** [***slt.mentalhealth@nhs.net***](mailto:slt.mentalhealth@nhs.net) *from NHS.net accounts only*

*Or add referral to Carenotes and email with NHS number to alert SLT to referral*