###### 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*** *from NHS.net accounts only*

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