Airedale NHS
NHS Trust

Speech & Language Therapy Service

Fax: 01535 293649

Referral for assessment of Dysphagia / Communication

Attach PAS Label: [ ]

Consultant: ______________________ Ward: ______

Date of Admission: ____/_____/____

Communication Problem: ☐ Yes ☐ No

Swallowing Problem: ☐ Yes ☐ No

Nil by Mouth: ☐ Yes ☐ No

First sip test completed Date: ____/_____/____

Continue to sip test daily until seen by SALT

Dysphagia Management Pathway started Date: ____/_____/____

Date of referral to SALT Date: ____/_____/____

Date referral received by SALT Date: ____/_____/____

Referred by: ___________________________________ print & sign name

Doctor/Nurse (delete as appropriate)

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