Airedale NHS
NHS Foundation Trust

THERAPY SERVICES

Referral to Adult Speech and Language Therapy Service

Please complete both sides of this form - Fax both pages on the day of referral

FAX 01535 293649

PATIENT DETAILS			
Surname		D.O.B	
Forename		NHS No.	
Title	Mr / Mrs /Miss / Dr / Other	AGH No.	
Address		Consultant	
		GP and Surgery	
Postcode			

Telephone Numbers (please circle preferred telephone number)			
Day Number : Evening Number: Mobile Number:			
Carer's Name (If relevant)		Carer's relationship to patient	
Carer's Telephone Number			

Other

Ethnicity:

Language (If not English): Interpreter required: Yes☐ No☐

Can the patient attend clinic: Yes☐ No☐ Transport needs: Yes☐ No☐

SC☐ T1☐ T2☐ W1☐ W2☐ STR☐ ESC☐

PRIORITY

Urgent (10 working days)☐ Routine (6 weeks)☐

Are there any known risks to staff? Yes☐ No☐

If Yes, please give details:

Are there any safeguarding issues? Yes☐ No☐

If yes please give details:

DIAGNOSIS, PAST MEDICAL HISTORY AND CURRENT MEDICATION

PATIENT DETAILS

Surname		D.O.B	

DETAILS OF SWALLOWING AND/OR COMMUNICATION PROBLEMS

OTHER SERVICES/AGENCIES INVOLVED AND SOCIAL SITUATION (designations and contact numbers)

CONSENT

Patient is aware of and has agreed to this referral Yes☐ No☐
If no, please explain

REFERRER

Date of referral:	Referrer designation:
Referrer name (please print):	Referrer signature:
Referrer's address:	Referrer's telephone number: **Referrer's fax number:**

THERAPY USE ONLY

Date Referral Received:

Please fax this form to 01535 293649 or post to Speech and Language Therapy Department, Airedale General Hospital, Keighley, West Yorkshire BD20 6TD Tel 01535 293641