CÚRAM SLÁINTE POBAIL
CORCAIGH CIARRAÍ
CORK KERRY
COMMUNITY HEALTHCARE

ADULT SPEECH AND LANGUAGE THERAPY REFERRAL FORM
for South Lee

*Please complete **ALL** sections in full, incomplete forms will be returned*

Please enclose copies of relevant reports to supplement the information on this form

Client's Personal Details

Name: _____

Date of Birth: _____

Address: _____

Telephone Number(s): _____

MRN if Known: _____

Other Contact person/family member: _____

Relationship to the client: _____

Telephone Number(s): _____

Referral Agent Details

Name: _____

Address: _____

Telephone Number: _____

E-mail: _____

GP Details

GP: _____

Surgery Address: _____

Telephone Number: _____

E-mail: _____

Reason for Referral

Please tick appropriate box.

Swallowing ☐ Communication ☐

Describe the presenting problem **in detail**:

_____

_____

_____

_____

Medical Details

Primary diagnosis: _____

Time of onset: _____

Consequences: _____

Current Medications: _____

_____

Previous Medical History: _____

_____

Other Agencies currently involved in therapy, training or rehabilitation

	Name	Address	Telephone
1.			
2.			
3.			
4.			

Additional Information

Please provide **any** other information (for example; physical, language, cognitive or visual impairments and/or behavioural issues) which need to be considered in planning service provision for this client:

_____

_____

_____

_____

_____

_____

Previous Speech and Language Therapy

Please provide any details of previous involvement with SLT if known:

_____

_____

_____

Name:
(please print clearly) _____

Signature: _____

Profession: _____

Date of Referral: _____

Please return the completed form by post to:

Speech & Language Therapy Department
City General Hospital,
Infirmary Road, Cork.
Eircode: T12 NV97

Alternatively, scan and email to: speechtherapy.sl@hse.ie

If you have any referral queries, please phone: 021-4927801