***1. Client details (please print):***

|  |  |  |  |
| --- | --- | --- | --- |
| **First name:** |  | **Last name:** |  |
| **Date of birth:**  |  | **Gender:** | Male ☐ Female☐ Other: |
| **Address:** |  |
| **Home no.:**  |  | **Mobile no.:**  |  |
| **Next of kin and relationship to client:** |  | **Contact Details:** |  |
| **Lives:**  | Alone🞎With family 🞎Other:  |
| **First Language:** |  | **Second Language:** |  |
| **Requires Interpreter:** | Yes ☐No☐ |

***2. Medical Information:***

|  |  |  |  |
| --- | --- | --- | --- |
| **GP Name & Address** |  | **Phone number:** |  |
| **Hospital:** |  | **Consultant:** |  |
| **Services involved:** | Physio 🞎 OT 🞎 Social Work 🞎 Dietician 🞎 PHN 🞎 Other *(name(s) & details)*: |
| **Infection Status:** | *(e.g. MRSA, HIV etc)* |
| **Medication:** |  |
| **Medical Diagnosis & History:** |  |
| **Reason for recent medical admissions:** |  | **Any investigations during admission:** |  |

***3. Referral Information:***

|  |  |  |  |
| --- | --- | --- | --- |
| **Area of concern:** | Speech 🞎 Language 🞎 Swallowing 🞎 Other: | **Reason for referral:** | Assessment 🞎 Rehab 🞎 Review 🞎 Palliative 🞎 Other: |
| **Previous SLT involvement:** |  |
| **Cognitive communication status:** |  |
| **Swallowing status:** | *(e.g. oral intake, modified foods/ fluids, assessment/ therapy completed):* |
| **Other relevant information:** |  |

***4. Consent:***

|  |  |  |  |
| --- | --- | --- | --- |
| **Has client consented to referral:** | Yes 🞎 No 🞎  **g.r: SA, HIV etc):\_\_\_ South We\_\_\_\_\_\_\_\_\_ Medical Team/ Primary Care Team prior to assessment:** | **Date of consent:** |  |
| **Has client consented to Primary Care Adult SLT contacting G.P./ Medical Team/ Primary Care Team, as appropriate, prior to assessment:** | Yes 🞎 No 🞎  |

***5. Referrer details:***

|  |  |
| --- | --- |
| **Referrer name** (**print**): |   |
| **Referring signature:** |  | **Job Title:** |  |
| **Location:**  |  | **Phone number:** |  |
| **Contact referrer prior to visit?** |  |

If this client presents with an **URGENT swallowing difficulty,** please **refer** them **directly** to **G.P./ A&E**

|  |
| --- |
| Please circle appropriate catchment area & return by post. For guidance on catchment areas: https://finder.healthatlasireland.ie/  |
| **Dublin South West (DSW)** | **Dublin West (DW)** | **Kildare West Wicklow (KWW)** | **Dublin South City (DSC)** |
| *Adult Senior Speech & Language Therapist*HSE, DSW, Russell Building, Tallaght Cross West, Tallaght, Dublin 24 | *Adult Senior Speech & Language Therapist*HSE, DW, Acorn Unit, Cherry Orchard Hospital, Ballyfermot, Dublin 10 | *Adult Senior Speech & Language Therapist*HSE, KWW, Clane Primary Care Centre, Abbeylands, Clane, Co. Kildare | *Adult Senior Speech & Language Therapist*HSE, DSC, The Meath Primary Care Centre, 1-9 Heytesbury Street, Dublin 8 |

 Please **attach copies** of **all** **relevant written reports.** Only **completed** referral forms will be accepted.