

**DYSPHAGIA CLINIC REFERRAL**

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| Referral Date |  |

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| Patient Details |
| Full name |  | GP name |  |
| Address |  | GP address |  |
|  |  |
|  |  |
| Post code |  | Post code |  |
| Telephone |  | Next of Kin |  |
| Date of birth |  | Relationship |  |
| NHS number |  | Telephone  |  |
| First Language |  | Interpreter required |  Yes  No  |

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| Referral Details |
| Referrer name |  | Designation |  |
| Telephone |  | Base |  |
| Previous medical history |  |
| Reason for referralTick all that apply |  Dysphagia with structural cause requiring ENT review Complex dysphagia Dysphagia of unknown cause MDT approach to dysphagia management required Unresolving dysphagia OtherPlease provide details: |
| Current means of nutritione.g. oral intake consistencies / non-oral feeding | Is this patient feeding at risk of aspiration?  Yes  No |
| Previous instrumental assessments |  Videofluoroscopy FEES Other (please state) Report(s) attachedIf reports not attached, please provide summary of findings: |

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| Signature: |
| Please send referrals to: Tahseen.Hashmi@uhcw.nhs.uk |
| For enquiries, please contact UHCW Adult SLT Department on 02476 965709 |

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| **Clinic Use Only** |
| Date & Time Received |  | Referral Criteria Met |  Yes  No |