

**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 referral  Tick all that apply |  Dysphagia with structural cause requiring ENT review   Complex dysphagia   Dysphagia of unknown cause   MDT approach to dysphagia management required   Unresolving dysphagia   Other  Please provide details: | | |
| Current means of nutrition  e.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) attached  If 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 |