NHS
South Warwickshire
NHS Foundation Trust

Speech & Language Therapy Referral Form - Community Team

Name of Patient:
D.O.B:
NHS Number:
Contact Tel Number:
Diagnosis & Recent Medical history:
Reason for Referral: (*please tick boxes as required)* **Swallowing problem** ☐ **Communication problem** ☐
Nature of swallowing difficulties (dysphagia):
Nature of communication difficulties:
Any previous SLT input / recommendations & date:
Name of GP Surgery:

Any other relevant information:
Who to contact to arrange an appointment (e.g. patient or family member)?
Has person consented to referral: **Yes** ☐ **No** ☐ *(Please tick box)*

Referrer's name (print):	**Address & Contact No of Referrer:**
Job Title/Profession:	**Date of referral:**

Please note if insufficient information is provided above the referral will be returned.

Please email referral to: swft.adultsalt@nhs.net