ADULT SPEECH PATHOLOGY

Home, Aged Care and Hospital Service

Adult Neurological - Communication and Swallowing Difficulties

REFERRAL FORM FOR SPEECH PATHOLOGY

❑ **Urgent** *(within 2 business days)* ❑ **Non-urgent** *(within one week)*

Site: ……………………………………………………………………………………………

Resident details:

Name: ………………………………………….**Date of Birth:** ...…………………………………...

Reason for referral: ……………………………………………………………………...............

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Referral requested by:

❑ Resident's Doctor (GP)
❑ Nursing Staff
❑ Resident
❑ Resident's family
❑ Other……………………………………

Relevant Medical History includes: *(Tick all applicable)*

❑ L CVA
❑ R CVA
❑ Dementia
❑ Parkinson's Disease
❑ Other neurological ……………

❑ Respiratory; please specify ………………
❑ Diabetes
❑ Food allergy
❑ Ca
❑ Other; please specify ………………………..

Current diet and fluids:

Diet
❑ Regular (IDDSI RG7)
❑ Regular Easy to Chew (IDDSI EC7)
❑ Soft and Bite-sized (IDDSI SB6)
❑ Minced and Moist (IDDSI MM5)
❑ Pureed (IDDSI PU4)
❑ Liquidised (IDDSI LQ3)
❑ Nil orally / PEG

Fluids
❑ Thin (IDDSI TN0)
❑ Slightly thick (IDDSI ST1)
❑ Mildly Thick (IDDSI MT2)
❑ Moderately Thick (IDDSI MO3)
❑ Extremely Thick (IDDSI EX4)
❑Nil orally / PEG

Oral Medications
❑ Whole
❑ Crushed
❑ Not applicable

Referral completed by:

Signature: ……………………………… Printed Name: …………………………
Position: ……………………………….. Contact Number: ……………………
Date: ……………………..

To refer resident for Speech Pathology assessment, please

– Email: enquiries@adultspeechpath.com*(*emails preferred*), or
– Fax to (08) 8271 1588, or
– Phone (08) 8274 1551

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