**MEDICAL REFERRAL FORM (to accompany signed Radiology request form)**

**For maximal care of your patient, please select relevant site based on clinical history:**

**❑ RAH ❑ TQEH**

Outpatient Referral Hub Speech Pathology Department

Royal Adelaide Hospital Level 1 Allied Health Building

1 Port Rd THE QUEEN ELIZABETH HOSPITAL

North Terrace 28 Woodville Road

ADELAIDE, SA 5000 WOODVILLE, SA 5011

RAH PHONE: (08) 7074 0000 TQEH PHONE: (08) 8222 6734

RAH FAX: (08) 7074 6247 TQEH FAX: (08) 8222 8021

**Please contact relevant Speech Pathology service if further discussion or advice is required.**

**Access criteria for Outpatient Speech Pathology Swallow Study:**

* **Cognition:** Patients with cognitive/ behavioural issues must be accompanied by a carer and be able to

provide consent personally or by proxy.

* **Mobility:** Independent mobility *or* wheelchair sitting stability is required for up to 2 hours.
* **Continence**: Independent toileting *or* carer-assisted toileting, *or* incontinence aids protection is required.
* **Speech Pathology Clinical Assessment of swallowing prior to radiological DF SP swallow study is required (This may be arranged at site of referral if not seen elsewhere)**.

*If an external Speech Pathologist is involved, they should attend the assessment and are responsible for ongoing management, liaison, patient/carer education and external documentation.*

**Outpatient DF Speech Pathology Swallow Study services are unable to be provided if the above criteria are not met.**

***PATIENT INFORMATION:***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: / / UR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOK /Contact person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carer /Care Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter Required: 🞏 YES 🞏 NO Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Next of Kin consent given for referral & information exchange with other professionals: 🞏 YES 🞏 NO

***REFERRAL INFORMATION:*** Please document below or attach referral letter.

Medical Referrer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MEDICAL INFORMATION:*** Please document below or attach patient history.

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_