**CLIENT DETAILS
Name: DOB:**

**Address: Contact telephone number:
 Email:

Next of Kin (including contact details):**

**GP contact details:**

**Nature of Communication difficulties:** *including SLT diagnosis, assessment results, and detail of presentation.*

**Relevant Medical History / Aetiology:** *including CT results, medication*

**Mobility**: unaided / stick / wheelchair / frame / assistance needed Hemiplegia Left/Right

**Hearing deficit**: yes / no left / right aid supplied: yes / no aid used: yes / no

**Visual deficit**: yes / no glasses needed: yes / no

**Summary of Previous SLT intervention**: *including timing, client’s response to therapy*

**What further intervention do you feel would be appropriate for this client?**

**Client is aware of and consents to this referral, including student involvement Yes/No**

**Referrer’s Details**

**Name:**

**Address:**

**Contact telephone number: Email address:**

**Please include a recent SLT report with this referral**