NATIONAL REFERRAL FORM
FOR SECOND OPINION ASSESSMENT OF VELO-PHARYNGEAL DYSFUNCTION FOR SPEECH
(FOR SPEECH AND LANGUAGE THERAPISTS)

CLIENT DETAILS			
Surname:	**First Name**		**Known As:**
Gender: Male ☐ Female ☐	**DOB**		
Address:	**Landline:**		
	Mobile:		
Contact person (carer/guardian):	**Relationship to client:**	**Contact Number:**	
Next of Kin (for adult clients):	**Relationship to client:**	**Contact Number:**	
Languages Spoken		**Interpreter required** YES ☐ NO ☐	
GP Name/Practice	**GP Contact Number**		
GP Address			
List any other services/ agencies involved in the client's care:			

GENERAL REFERRAL DETAILS	
Relevant medical / developmental history*(please note if client has had an adenoidectomy):*	
Does the client have any hearing issues? If yes, please elaborate:	
Does the client have any eating/drinking/ swallowing/ nasal regurgitation issues? If yes, please elaborate:	

Summary of most recent speech and language review *(please attach the most recent report if available):*	
How long was the client's most recent block of therapy and what were the targets covered?	

REASON FOR REFERRAL			
Resonance	Suspected hyper-nasality ☐	Suspected hypo-nasality ☐	Not sure ☐
Nasal Airflow	Suspected passive nasal emission ☐	Suspected passive nasal turbulence ☐	Not sure ☐
Is client presenting with active nasal fricatives?	Yes ☐ No ☐ Not sure ☐		
Please list all consonants the client can use spontaneously:			
Is the client stimulable for any consonants he/she is not using spontaneously?	Yes ☐ No ☐ If Yes, please list:		
Reason for referral			

Please indicate which team you would like the client to be referred to

Please only refer to **one team**

☐ Children's Health Ireland at Crumlin / St James's Hospital	☐ Children's Health Ireland at Temple Street	☐ University Hospital Galway	☐ Cork University Hospital
If ticked please send referral to the following- *For clients* ***under 5 years of age***: Orla Forde/ Christina Cotter, Senior Speech and Language Therapist, Our Lady's Children's Hospital, Crumlin, Dublin 12. (Tel. 01-4096198) *For clients* ***aged 5 years-adulthood****:* Aisling O Dwyer, Senior Speech and Language Therapist, Brookfield House, St James's Hospital, Dublin 8. (Tel. 01-4162635)	If ticked please send referral to the following- *For clients* ***under 16 years of age***: Nóirín Carroll, Clinical Specialist Speech and Language Therapist, Children's University Hospital, Temple St. Dublin 1. (Tel. 01-8784872)	If ticked please send referral to the following- *For clients* ***under 16 years of age***: Niamh Ward, Senior Speech and Language Therapist, University Hospital Galway, Newcastle Road, Co. Galway. (Tel. 091-542160)	If ticked please send referral to the following: *For clients* ***under 16 years of age:*** Claire Mansfield, Senior Speech and Language Therapist, Shandon Suite, 1st Floor, Cork University Hospital, Wilton, Co Cork. (Tel. 021-4922880)

REFERRER details		
Name:	**Title:**	**Date:**
Address:	**Telephone:**	**Email:**
Signature:	**Preferred Contact Method:** Post ☐ Telephone ☐ Fax ☐ Email ☐	
Should the client's correspondence from our service be copied to any other party? If yes, please give details:		