**ADULT COMMUNITY SPEECH AND LANGUAGE THERAPY REFERRAL FORM**

PLEASE REFER TO THE REFERRAL GUIDANCE WHEN COMPLETING THIS FORM

**PLEASE NOTE ALL SECTIONS MUST BE COMPLETED**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patients Surname:** | |  | | | **Patients First Name:** | | | | | | |  | |
| **DOB**: | |  | | | **Likes to be known as:** | | | | | | |  | |
| **NHS No:** | |  | | | **Gender:** | | | | | | | Male / Female / Neutral | |
| **Address:** | | **House Name / Number / Street:** | |  | | | | | | | | | |
| **Town / City:** | |  | | | | | | | **Postcode:** | |  |
| **Email address:** | |  | | | | | **Tel No:** | |  | | | | |
|  | | | | | | | | | | | | | |
| **Next of Kin Name(s):** | | |  | | | | | | | | | | |
| **Next of Kin Email:** | | |  | | | | | | | | | | |
| **Next of Kin Mobile No:** | | |  | | | | **Home No:** | | |  | | | |
|  | | | | | | | | | | | | | |
| **GP Name & address:** | | |  | | | | **Consultant:** | | |  | | | |
| **Languages** **spoken**: | | |  | | | | **Interpreter** **required**: | | | | | Yes  No   If yes, specify language: | |
|  | | | | | | | | | | | | | |
| **Referral completed by:** | | |  | | | **Role:** | |  | | | | | |
| **Contact Address:** | | |  | | | | | | | | | | |
| **Contact Tel No:** | | |  | | | **Email:** | |  | | | | | |
|  | | | | | | | | | | | | | |
| **Consent**: | **Does the patient have capacity to consent to this referral?**  Yes  No | | | | | | | | | | | | |
| **Has the patient consented to this referral?**  Yes  No | | | | | | | | | | | | |
| **If the patient lacks capacity, is the referral being made in their best interests?** Yes  No | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Reason for referral:** | | **Communication**: Yes  No | | | | | **Swallowing**: Yes  No | | | | | | |
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| **Domiciliary Circumstances:** | | **Does the patient attend appointments outside of the home?** Yes  No | | | | | | | | | | | |
| **Who does the patient live with:** | |  | | **Care Agency  name and address:** | | | | | |  | | | |
| **Key safe number:** | |  | | **Detail any risks associated with home visits:** | | | | | |  | | | |
|  | | | | | | | | | | | | | |
| **What other agencies are involved, for example, Social Services/Health professionals?** | | | | | | | | | | | | | |
| **Agency** | | **Named person** | | | | | **Contact address/telephone/email** | | | | | | |
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| **Previous medical diagnoses and date of diagnosis:** | | | | | | | | | | | | | |

**PLEASE NOTE ALL SECTIONS MUST BE COMPLETED**

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| **COMMUNICATION REFERRAL - FURTHER INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please describe patients communication below (refer to supporting guidelines):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **DYSPHAGIA REFERRAL - FURTHER INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **When has the patient been prescribed antibiotics for chest infection(s) in the past 12 months?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| None | Jan | Feb | Mar | | April | | | May | | June | | | | July | Aug | | | Sept | | | Oct | | Nov | | | | | Dec | Unknown | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Has he/she lost weight in the last 3 months?** | | | | | | | | | | | | | | | | | | | Unknown  Yes  No | | | | | | | | | | | |
| 1. **Has he/she had any urine infections in the last 6 months?** | | | | | | | | | | | | | | | | | | | Unknown  Yes  No | | | | | | | | | | | |
| 1. **Does he/she have difficulty staying awake for more than 10 minutes?** | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| 1. **Does eating and drinking cause distress to either the client or carer?** | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| 1. **Does he/she have a PEG (feeding tube)?** | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
| 1. **Is the patient Nil by Mouth?** | | | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Has the person PREVIOUSLY been given diet/fluid texture recommendations by Speech & Language Therapy (SALT)?** | | | | **Diet IDDSI level** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Level 3  Liquidised | | | | | Level 4  Pureed | | | | Level 5  Minced & Moist | | | Level 6  Soft & Bite sized | | | | | | Level 7  Easy to chew | | | | Regular | | | | No |
| **Fluid Texture** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Thin | | | Level 1  Slightly thick | | | | Level 2 Mildly thick | | | | | | Level 3 Moderately thick | | | | | | | | Level 4 Extremely thick | | | | | No |
| 1. **What food/fluids are a problem for the patient? Please specify** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **When taking the problem textures, what of the following has the patient experienced?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Observation** | | | | | | **Food** | | | | | | **Frequency** | | | | | | | | **Fluids** | | | | | | | **Frequency** | | | |
| **Throat clearing** | | | | | | Yes  No | | | | | | Choose an item. | | | | | | | | Yes  No | | | | | | | Choose an item. | | | |
| **Coughing episodes** | | | | | | Yes  No | | | | | | Choose an item. | | | | | | | | Yes  No | | | | | | | Choose an item. | | | |
| **Explosive coughing** | | | | | | Yes  No | | | | | | Choose an item. | | | | | | | | Yes  No | | | | | | | Choose an item. | | | |
| **Choking (gagging, difficulty coughing and breathing)** | | | | | | Yes  No | | | | | | Choose an item. | | | | | | | | Yes  No | | | | | | | Choose an item. | | | |
| **Other (please specify)** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Have you made any modification to the patient’s diet and has this helped? Please specify** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **What foods/fluids is the patient taking successfully?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**ADULT COMMUNITY SPEECH AND LANGUAGE THERAPY REFERRAL FORM GUIDANCE**

All referrals must be on the official form.

All sections of page 1 of the form must be completed - **incomplete forms will be returned.**

Page 2 – please complete relevant sections e.g. communication/dysphagia

If a section is not applicable please state this on the form.

**Demographics:**

Please complete all boxes to provide details.

**Communication:**

1. Please specify the patient’s communication difficulty:

* **Clarity of speech** – the patients speech is unclear
* **Understanding instructions** – the patient struggles to follow written or verbal instructions
* **Finding words/constructing sentences** – words are jumbled up or missing from their sentences
* **Stammer** – the patients speech is not fluent; they may experience repetitions e.g. p,p,p,p,please or prolongations of sounds in words e.g. pleeeeeeeeeeease
* **Voice** – they may have lost their voice completely or their voice tone/quality may be impaired. Please ensure you attach the letter from the ENT Consultant, the consultation needs to have been completed in the last 6 months. We are currently accepting Post-Covid Voice referrals prior to ENT Consultation being completed.
* **Writing** has deteriorated due to a medical condition
* **Reading** has deteriorated due to a medical condition

1. Please comment on the impact of their communication difficulty on the patient:

* Unable to communicate by any means
* Able to communicate in a limited way
* Able to communicate but experiencing difficulties
* The patients severity of frustration or distress – severe, some, slight, none

1. Please specify if the patient has a communication aid

**Dysphagia:**

Please note the terminology for diet/texture changed in 2019 [www.IDDSI.org](http://www.IDDSI.org)

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| **FOOD** | | | | | | | | | | |
| **IDDSI terminology** | **Level 3: Liquidised** | | **Level 4:**  **Pureed** | **Level 5:**  **Minced & Moist** | | **Level 6:**  **Soft**  **& Bite-sized** | | **Level 7:**  **Easy To Chew** | | **Level 7: Regular** |
| *Previously known as* | *Thin Puree*  *(Cat B)* | | *Thick Puree*  *(Cat C)* | *Pre-mashed*  *(Cat D)* | | *Fork Mashable (Bread not allowed)*  *(Cat E)* | | *Fork Mashable (Bread allowed)*  *(Cat E)* | | *Normal* |
| **FLUIDS** | | | | | | | | | | |
| **IDDSI terminology** | **Level 0: Thin** | **Level 1:**  **Slightly thick** | | | **Level 2:**  **Mildly thick** | | **Level 3: Moderately thick** | | **Level 4:**  **Extremely thick** | |
| *Previously known as* | *Normal* | *Naturally thick* | | | *Syrup thick* | | *Custard thick* | | *Pudding thick* | |