**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**

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| **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 [ ]  |
|  |
| **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):**  |
|  |
| **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 3Liquidised[ ]  | Level 4Pureed[ ]  | Level 5Minced & Moist[ ]  | Level 6Soft & Bite sized[ ]  | Level 7Easy 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**
 |
|  |
| 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* |