

**ADULT SPEECH & LANGUAGE THERAPY REFERRAL FORM**

**Please see exclusion criteria attached before completing this form.**

**We will not accept a referral if the individual meets these criteria.**

**FAO Care Homes/Nursing Homes Only:** Please note, you will need to evidence completing the *Managing Dysphagia Checklist* at the time of referral. Referrals made without sending a copy of this checklist will not be accepted.

**Please fill in all pages as incomplete forms will be returned to referrer**

|  |  |
| --- | --- |
| **Individual’s name** |  |
| **Date of birth** |  |
| **NHS number** |  |
| **Address** |  |
| **Telephone number** |  |
| **Email** |  |
| **GP, surgery address and telephone number** |  |
| **Name and contact details of referrer and profession (if applicable)** |  |
| **Date of referral** |  |
| **Is GP aware of referral?** | **Yes / No If yes, date:** |
| **Does the individual consent to this referral?** | **Yes** |
| **Does the individual have any of the following? (please tick as appropriate)** | * **Lasting Power of Attorney for Health** * **RESPECT form yes** * **Advanced Care Plan** |
| **Any other Professionals involved?** |  |
| **Is an interpreter required?** | **Yes / No If yes, which language?** |
| **Does the individual live alone?** |  |
| **Are there any risks to visiting this individual?** | **Yes / No If yes, what are the risks?** |
| **Can they access a video consultation?** |  |
| **Can they access a clinic?** |  |
| **Diagnosis and Medical History** |  |
| **Is the individual on Gold Standards Framework (GSF)?** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Reason For Referral (please tick as appropriate)** | | | |
| **Swallowing** |  | **Stammering** |  |
| **Communication** |  | **Voice** |  |

|  |  |
| --- | --- |
| **Communication / Stammering / Voice**  (please leave blank if referral relates to a swallowing difficulty) | |
| **Please detail the individual’s problem** |  |
| **When did this difficulty start?** |  |
| **How are they communicating now?** |  |
| **How is this impacting their daily life?** |  |

|  |  |  |
| --- | --- | --- |
| **Swallowing**  (please leave blank if referral relates to a communication difficulty) | | |
| **Symptoms (please tick as appropriate)** | * Repeated and / or recent chest infection combined with symptoms of swallowing difficulties * Coughing on food / drinks / saliva * Choking episodes (blocked airway) x reported to me * Problems breathing when eating / drinking * Wet / gurgly voice when eating / drinking * Other (please give details) | |
| **Does this occur every time the individual eats and / or drinks?** | **Yes / No** | |
| **If no, how often does this symptom occur?** |  | |
| **Is the swallowing difficulty causing weight loss or dehydration? (Please give details)** |  | |
| **Individuals current diet and fluid consistencies (tick as appropriate)** | | |
| **Diet texture** | **Texture:**   * Pureed (Level 4) * Minced and Moist (Level 5) * Soft and bite-sized (Level 6) * Regular (Normal) diet (Level 7) | **Amount Given:**   * Teaspoons * Dessertspoons * Knife and fork * Finger food |
| **Fluid consistency** | **Consistency:**   * Thin (Normal fluids) * Slightly thick (Level 1) * Mildly thick (Level 2) * Moderately thick (Level 3) * Extremely thick (Level 4)   **Uses:**   * Normal cup * Straw * Spouted beaker * Other (please specify) | **Amount Given:**   * Teaspoons * Single sips * Consecutive sips |
| **SONA (Care Homes only)** | | |
| **Has the individual been seen by a SONA?** | **Yes / No** | |
| **Name of SONA** |  | |

**Inappropriate reasons to refer and what to do instead:**

|  |  |
| --- | --- |
| **Presentation** | **Action** |
| Individual is too drowsy or unwell to manage sufficient oral intake | Discuss with GP / dietitian |
| Excess saliva with absence of any other swallowing difficulty including dribbling / drooling | GP to consider management of excess saliva |
| Difficulties chewing food due to poor dentition / ill fitting dentures but no other swallowing difficulty | * Trial denture adhesive * Offer foods requiring less chewing * Dental referral as appropriate |
| The individual has small appetite or poor fluid intake, or there is weight loss with no apparent swallowing difficulty | Consider referral to dietitian if individual meets dietetic team requirements |
| Vomiting or gastro-oesophageal problems (e.g. reflux, hiatus hernia) only | Discuss with GP |
| Problems swallowing tablets with no other swallowing difficulties | Request GP prescribe medicines in alternative forms or consult pharmacist for advice as to whether they can be crushed, cut or taken with a spoonful of yoghurt to make them easier to swallow |
| Individuals who have been assessed to have Mental Capacity to make choices about their own health and are refusing SLT input / recommendations | Ensure all discussions and decisions are documented appropriately and inform GP |
| Individuals who have the Mental Capacity to make choices about their own health and have chosen to risk feed. This would include risk feeding decisions made during a hospital admission | Ensure all discussions and decisions are documented appropriately and inform GP |
| Voice referrals for individuals who do not have an ENT report dated within the last 6 months | GP to refer to ENT |
| Individuals who are being managed safely by a SONA | Continue to follow SONA guidance |
| GP is out of area (even if the individuals address is within our area) | Please refer to service within GP geographical area |

**Exclusion Criteria**

**We are not commissioned to see the following:**

* Individuals who need advice regarding dyslexia
* Individuals that are on the Learning Disability Register (please refer to the Adult Learning Disability Speech and Language Therapy Service in LPFT)
* Individuals with mental health issues affecting communication
* Individuals with behavioural issues around eating/drinking with no dysphagia evident
* Individuals with a hearing impairment resulting in communication problems
* Referrals from private neuro rehab establishments
* Referrals for voice due to gender dysphoria
* Individuals with a diagnosis of dementia referred for advice on communication difficulties
* Individuals who need advice and treatment for Chronic Cough
* Individuals with a diagnosis of FND
* Referrals where communication difficulties are longstanding and there has been no acute change or need identified for new referral.
* Diagnosis of Pharyngeal Pouch

**Contact details for submitting the completed referral form and enquiries:**

Adult Speech and Language Therapy Admin Hub

Bourne Health Clinic

St Gilberts Road

Bourne

Lincolnshire

PE10 9XA

Telephone: 01778 426149

Email: LHNT.SLT@nhs.net