**Care Home Speech and Language Therapy Referral Form**

**Please complete this form in full as incomplete referrals will be returned**

**Has the Dysphagia Management Checklist been completed prior to referring to our service?** (Double click in appropriate box and click on ‘Checked’)

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| Yes No (If no, please complete this checklist before referring the resident to our service. Referrals received without completing this checklist will not be accepted. |

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| **Patient Name:** |  | **NHS Number:** |  |

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| **Current Address / Postcode:** |  |

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| --- | --- | --- | --- |
| **Date Of Birth:** |  | **Telephone Number:** |  |

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| --- | --- | --- | --- |
| **Name Of GP / Surgery:** |  | **Next Of Kin Name And Telephone Number:** |  |

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| **Has The Patient Consented To Referral:** | Yes No Unable To Consent |

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| **Reason For Referral:** | Communication Difficulty *(explain)*  Swallowing Difficulty *(complete questions below)* |

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| **Has The Person Been Seen By SLT Before:** | Yes *(please list previous eating and drinking recommendations)* No |
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| **Diagnosis And Past Medical History:** |  |

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| **Please Give Description Of The Problem / Reason For Referral:** |  |

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| **What Steps Have You Tried To Manage These Issues Before Referring?** *Using the* ***Managing Dysphagia Checklist*** *list the signs / symptoms you have observed as per the document number and note what management strategies have been trialled.* |
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| **How Often Does The Problem Occur:** | Every Meal / Drink  Daily  Several Times / Week |

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| **What Is The Current Consistency Of Fluids?**  Level 0 Thin  Level 2 Mildly Thick Level 4 Extremely Thick    Level 1 Slightly Thick Level 3 Moderately Thick |

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| **What Is The Current IDDSI Diet Level?**  Level 3 Liquidised  Level 5 Minced And Moist Diet Level 7 Regular Easy To Chew Diet  Level 4 Pureed diet Level 6 Soft And Bite-Sized Diet Level 7 Regular Diet |

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| **If You Have Completed A Food / Fluid Diary Please Include A Summary Of The Findings** *(e.g. frequency of coughing, duration of coughing, signs of distress when eating / drinking)* |
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| **Has This Resident Had Any Confirmed Unexplained Chest Infections In The Last 3 Months (Requiring Medication)?** | Yes (If yes, how many? )  No |

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| **Referrer Name:** |  | **Job Title:** |  | **Referral Date:** |  |

**PLEASE ENSURE YOU HAVE COMPLETED ALL SECTIONS**

Return completed forms to [adultsltreferrals@somersetft.nhs.uk](mailto:adultsltreferrals@somersetft.nhs.uk) Adult SLT Service Tel: 01823 617464