**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 Adult SLT Service Tel: 01823 617464