## Referral Doncaster GP and Non-care home

**Community Speech and Language Therapy Referral Form (Non Care home**¹**)**

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| **DETAILS OF PERSON BEING REFERRED** |
| Name:  | Date Of Birth |
| NHS Number | Preferred Contact number |
| Address | Person to contact in an emergency  |
| Has the individual consented to referral? (please circle) Yes NoLacks capacity for this decisionDecision made in persons Best Interest | If the individual lacks capacity and has a lasting Power of Attorney (Health and Welfare), has the relevant attorney consented to this referral? Yes / No |
| GP Name (MUST BE REGISTERED WITH A DONCASTER GP)GP Contact Number: | GP Address |
| **REFERRER DETAILS** |
|  Name  | Designation / Job Title |
| Contact NumberContact Email address:  | Date of Referral:Signature of Referrer |
|  |
| Medical History (please disclose all conditions or attach the information) |
| Medications (please disclose all medications or attach the information) |
| Is the individual receiving end of life care? (please circle)Yes No | Is the individual bedbound? (please circle) | YesNo |
| Could individual attend outpatient clinic?  | YesNo |

**Referral for (tick all that applies):**

* **Swallowing (please complete section 1)**
* **Communication (please complete section 2)**

**Section 1. Swallowing Referral**

**Please note:**

* **All parts of this section must be completed for the referral to be accepted; this is due to our high number of inappropriate referrals.**
* **Referrals for difficulties swallowing medications only, will not be accepted.**

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| **DOES THE PERSON CURRENTLY HAVE A CHEST INFECTION?** |
| YESNO If No, when was last chest Infection |
| **REASON FOR REQUESTING A SWALLOW ASSESSMENT** |
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| **Adverse signs during or shortly after DRINKING (fluids).** Please tick all that apply:  |
| Usual fluids taken (Please Circle) Level 0 (thin) Level 1 (slightly thick) Level 2 (mildly thick) Level 3 (Moderately thick)Level 4 (extremely thick) |
| Coughing or throat clearing during drinking |  |  |
| Coughing shortly after drinking |  |  |
| Wet / Gargly voice quality during or shortly after drinking |  |  |
| Change in face colour or breathing pattern during or shortly after drinking |  |  |
| Drinks dribbling from the mouth |  | Left SideRight Side |
| Request for upgrade of modified Fluids (improved swallow) |  |  |
| **Other** (Provide Details) e.g coughing whilst laying down (when not eating/drinking), Coughing at Night (when not eating/drinking)Provide details: |
| **Adverse signs during or shortly after EATING (Diet).** Please tick all that apply: |
| **Usual Diet taken (please circle)**Level 4 (pureed) Level 5 (Minced and Moist) Level 6 (Soft and Bite-Sized) Level 7 Easy Chew Level 7 Regular |
| Coughing or throat clearing during eating  |  |  |
| Coughing or throat clearing shortly after eating  |  |  |
| Holding food in the mouth with difficulty chewing and/or initiating the swallow |  |  |
| Pocketing food or food residue in the mouth after swallowing |  |  |
| Sensation of diet sticking in the throat after swallowing (not feeling food has fully cleared)Please mark where on the image |  |  |
| S**i**ngle choking episode (airway is blocked) |  | On What? When? |
| Multiple Choking Episodes (airway is blocked) |  | On What?When? |
| Request for upgrade of modified diet (improved swallow) |  |  |
| Other (provide details)e.g coughing whilst laying down (when not eating/drinking)Coughing at Night (when not eating/drinking) | Provide Details: |

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| **WEIGHT LOSS** |
| How much over how many weeks/months?  |  |
| Have you provided first line advice, such as food fortification, high calorie snacks and drinks?  | Yes / No  |
| Have you referred to dietetics?  | Yes / No |

Other. Please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **How are Fluids Taken?**  | **How is Diet Taken?**  |
| Independently  | Independently |
| With assistance | With Assistance |
| Open Cup |  |
| Specialist Cup |  |
| Lidded Beaker | From a spoon (Size):  |
| Spouted Beaker  | From a fork |
| From a Straw |  |
| From a Spoon (Size) |  |
| Other:  |

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| **Mouth care** |
| How many times does the individual clean their teeth/ complete mouth care per day?  |  |
| Are antibacterial products used?  | Yes / No  |

The website ‘Mouth Care Matters’ (https://mouthcarematters.hee.nhs.uk) provides information about the importance of mouth care and what equipment is required.

**Section 2. Communication Referral**

When and how did the problem start?

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Difficulties experienced (please tick all that apply):

* Slurred speech
* Difficulty finding or thinking of words
* Difficulty expressing themselves
* Difficulty understanding
* Difficulty reading
* Difficulty writing
* Quiet voice
* Changed voice
* Stammering
* Other; please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What would you and/or the individual like to get out of the referral?

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**Mental capacity assessment (MCA) support for individuals with communication disorders**

Is support needed for a mental capacity decision? Yes/ No

If ‘yes’, please complete the following questions:

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| What is the decision?  |  |
| Who is the decision maker? Please provide their full name and title. |  |
| Is there a deadline for this decision to be made?  |  |
| Who is the best person to liaise with?  |  |
| Please provide their contact details (number or email) |  |

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| Use this space to add any further information to the referral: |

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| If you can refer electronically from the patient record, please use this method of referral. Alternatively, please send completed referral forms to: The Speech and Language Therapy Team at rdash.rehabservices@nhs.netSpeech & Language Therapy ServiceNeuro ServicesTickhill Road Hospital SiteBalby, Doncaster, DN4 8QNTel: 01302 796336 |

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