## 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  No  Lacks capacity for this decision  Decision 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 Number  Contact 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) | Yes  No |
| Could individual attend outpatient clinic? | Yes  No |

**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?** | | |
| YES  NO If No, when was last chest Infection | | |
| **REASON FOR REQUESTING A SWALLOW ASSESSMENT** | | |
|  | | |
| **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 Side  Right 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.net](mailto:rdash.rehabservices@nhs.net)  Speech & Language Therapy Service  Neuro Services  Tickhill Road Hospital Site  Balby, Doncaster, DN4 8QN  Tel: 01302 796336 |

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