

**Speech & Language Therapy Adult Community EDITABLE Referral Form – Care Homes**

Please return by fax/post/email: **Email: Speechtherapycommunity.elht@nhs.net**

**Telephone number 01282 804075**

**Speech & Language Therapy Department, Area 1 level 2, Outpatients suite 3**

**Burnley General Teaching Hospital, Casterton Avenue, Burnley BB10 2PQ**

**Considerations prior to a swallowing referral**

If you are considering making a referral for swallow assessment, please answer the following questions first to ensure the referral is appropriate. If the answer is no to any of the questions below then please implement the advice given before proceeding with the referral.

**Is any existing SLT swallowing advice being correctly implemented? YES** [ ]  **NO** [ ]

For example, if a pureed (texture C) diet has been advised, ensure it is smooth with no lumps. Talk to kitchen staff about varied provision of appetising and appealing foods of the correct consistency.

Ensure fluids are thickened to the correct consistency- check dosage on packs of thickening powder for guidance and check it corresponds to the size of cup being used.

**Is the resident happy to comply with the current swallowing advice? YES** [ ] **NO** [ ]

Have you done everything possible to ensure that food is appetising and appealing? Speak to kitchen staff regarding modified diets and get them to seek advice from SLT and dietetics. Ensure thickened drinks are not overthickened and that hot thickened fluids are served hot. For cold thickened fluids, serve chilled and consider fizzy drinks such as lemonade which have a pleasing texture when thickened.

**Is resident in an upright position for all feeding?** **YES** [ ]  **NO** [ ]

Aim to sit the resident upright in a chair for feeding where possible.

**Is your resident, who has recently been in hospital where they were placed on a modified diet and / or fluids, still acutely unwell / not back to normal? YES** [ ]  **NO** [ ]

For example, if a resident has recently been discharged from hospital on a modified diet and you feel confident they have returned to their normal presentation, you can consider cautious reintroduction of more textured foods without SLT assessment. If the resident’s condition has improved since you referred to SLT please contact us to cancel the referral.

**Are dentures available and being worn for feeding?**  **YES** [ ]  **NO** [ ]

**Have you tried strategies to adjust size of sips / mouthfuls?**  **YES** [ ]  **NO** [ ]

Encourage single, steady paced sips. Consider alternatives to spouted cups and straws. If a spout is the only means possible then be very careful to ensure single small sips, removing the spout between sips. Try a teaspoon with foods to limit bolus size.

**Have you adjusted the environment to facilitate feeding?** **YES** [ ]  **NO** [ ]

Minimise distractions, encourage and assist to a greater degree as required.

You should **not** refer to SLT if:

* The issues are gastrointestinal / oesophageal in nature e.g. vomiting, gastrooesophageal reflux.
* A resident is clinically stable i.e. the resident coughs occasionally but has had no recent chest infections / signs of chronic aspiration.
* The resident is enjoying food and drink in good amounts with no significant distress on swallowing and no recurrent signs of aspiration.The resident has capacity to make their own decisions regarding eating and drinking but is choosing to take less safe food and drink. In these cases the care home documentation should reflect the patients mental capacity, the advice they been given and the choices they are making.

Date of referral ………………..............

|  |  |  |
| --- | --- | --- |
| **Name of Patient** |  | **Date Of Birth:** |
| **Telephone Number** |  |
| **Address** |  |
| **NHS number if known** |  |
| **Next Of Kin &****Relationship to Patient** |  | **Telephone Number:** |
| **GP name / Practice** |  |
| **Diagnosis & Medical History** |  |
| **Allergies** |  |
| **First Language** |  | **Is an interpreter needed? Yes** [ ] **No** [ ]  |
| **Known Risks to Staff** |  |

**REFERRAL FORM**

Why are you referring this person to SLT?

**Communication** [ ]  **Swallowing ⁭** [ ]

**Swallowing**

1. Describe the problem(s) with the individual’s swallowing? Has there been a change in function?

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1. Current food and fluid consistencies:

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1. Have they had any recent chest infections? **Yes** [ ]  **No** [ ]

If so, when?

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1. Has there been any recent weight loss? **Yes** [ ]  **No** [ ]

If so, how much?

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1. Any other information

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**Communication**

1. Describe the problem(s) with the individual’s communication:

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1. Does the person understand what you are saying?

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1. Can you understand their speech?

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1. Any hearing problems? **Yes** [ ]  **No** [ ]

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1. Any visual problems? **Yes** [ ]  **No** [ ]

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1. Any other information:

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**Incomplete referrals will be returned to the referrer**

**All referrals will be triaged and prioritised upon receipt**

**Please telephone the department if you wish to discuss the suitability of a referral further.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of referrer**  |  | **Signature** |  |
| **Job role** |  | **Date** |  |
| **Telephone Number** |  |
| **Address** |  |

*Office use only*

|  |  |
| --- | --- |
| *Previous SLT input Yes*[ ]  *No* [ ]  | *Previous notes requested ⁭ Received ⁭* |
| *Year of discharge*  | *Priority rating* |
| *Date referral received* |  |