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**Referral Form: Care Homes and Dysphagia ONLY**

**This form is for referrals for residents with swallowing problems from nursing or care staff only. PLEASE REFER TO THE CARE HOME PACK or contact SLT office on 01992 938462 when completing this form.**

**Please complete both pages *in full*, otherwise you will delay your resident being seen.**

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| **Patient’s name:** |  | **Referrer’s name:** |  |
| **D.O.B:**  **Ethnicity:** |  | **Referrers job title:** |  |
| **NHS no:** |  | **Date of referral:** |  |
| **Name and address of care home:** |  | **GP name and address:** |  |

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| **Has the resident consented to the referral?**  ☐ Yes ☐ No ☐ Unable (does not have capacity to consent to referral). |
| **RELEVANT MEDICAL HISTORY and CURRENT DIAGNOSIS:**  ☐ Stable ☐ Improving ☐ Deteriorating ☐ End of life ☐ Dementia \*please refer to page 11 in pack |
| **DETAILED DESCRIPTION OF SWALLOWING PROBLEM** – What are your concerns and why do you think they need assessment?  (For example: food/drink spilling from mouth, prolonged chewing, holding food in mouth, effortful swallow, choking, coughing, throat clearing, multiple swallows, wet voice, chest infections) |
| What **POSITION** do they eat and drink in & **WHERE** are they for meals? |
| Does this resident require **SUPPORT** at meal times? \*please refer to page 7-8 in pack  ☐ Independent with eating and drinking ☐ Need some assistance ☐ Need full help to eat and drink |
| **METHOD OF INTAKE?**  ☐ Oral feeding/drinking only ☐ PEG/ RIG + some oral ☐ PEG/ RIG only and nil by mouth |
| Difficulties swallowing **MEDICATION?** ☐ \*Yes ☐ No \*please refer to page10 in pack  Please ask the GP / pharmacist to review which can be given in a soluble/crushable form, and refer to our advice pack. Confirm this has been done ☐ Yes ☐ No  **There is no need to refer if this has resolved the problem.** |
| **Has the patient lost weight?** ☐ Yes ☐ No  Have you? ☐Discussed with GP ☐ Discussed with Dietician ☐ Tried fortifying foods/drinks  Do they have any oral **NUTRITIONAL SUPPLEMENTS**, if so please give details. |
| |  |  | | --- | --- | | Has the patient had any **CHEST INFECTIONS** (in the absence of a cold?) ☐ Yes ☐ No | No. of chest infections and dates (if available) | |
| **COUGHING:**  **When do they cough?** ☐ Only when eating/drinking ☐ At other times of the day ☐ At night  **FOOD/DRINKS** 1)☐ **What are they currently having? 2)** ☐ **Are they coughing on this?**  \*refer to IDDSI chart in pack, page 12  ☐ ☐ Level 7 – Normal diet ☐ ☐ Level 0 – Thin fluids  ☐ ☐ Level 6 – Soft & bite sized ☐ ☐ Level 1 – Mildly thick fluids  ☐ ☐ Level 5 – Minced & moist ☐ ☐ Level 2 – Mildly thick fluids  ☐ ☐ Level 4 – Pureed food ☐ ☐ Level 3 – Moderately thick fluids  ☐ ☐ Level 4 – Extremely thick fluids  **How frequent is the cough?**  ☐ Every sip/mouthful  ☐ At some stage during every meal/drink (please circle **here** food/fluids/both)  ☐ Once or twice a day  ☐ Every now and then  **How severe is the cough?**  ☐ Severe, needing help to recover, i.e. back slaps  ☐ Severe, but able to recover independently  ☐ Moderate  ☐ Mild/throat clearing |
| If the resident is already having modified food or drinks, **who placed the patient on these recommendations**? (please tick as appropriate)  ☐ **GP** ☐ **Previous SLT assessment** ☐ **Nursing/care staff** ☐ **Don’t know** |
| What has been **TRIED SO FAR** to manage the difficulties? e.g. texture changes, feeding techniques, positioning? \*please refer to pages 7-8 in pack  1.  2.  3.  If changes have already been made e.g. to food textures, positioning, that have reduced the symptoms of concern, ***then there is no need to refer to SLT***. People **newly** having thickened fluids do require SLT assessment (even if the GP has already prescribed the thickener). |
| **Given the changes you have tried, what is still concerning you?** i.e.How will the patient benefit from a specialist SLT assessment of swallowing? |
| Does the patient have mental capacity to make decisions about their food and drink?  ☐ Yes ☐ No |
| **Please send all referrals to: Speech and Language Therapy Department,**  **Ground Floor, Epping Forest Unit, St Margaret’s Hospital,**  **The Plain, Epping CM16 6TN**  **Tel: 01279 827621**  **Email:** [epunft.AdultSLT@nhs.net](mailto:epunft.AdultSLT@nhs.net) |