**Paediatric speech and language therapy**

**referral form guidance - dysphagia**

**Please complete this form if you have concerns about a child’s eating and drinking**

If you have concerns about a child’s fluency, voice or communication please use an alternative form available on the website here: <https://www.bdct.nhs.uk/how-to-refer-a-child/>

**Before completing this form, please refer to the referral criteria for eating and drinking here:** <https://www.bdct.nhs.uk/how-to-refer-a-child/> **to help you decide if a referral to speech and language therapy is appropriate.**

**Please ensure all relevant parts of the referral form are completed, if not, your referral may be rejected.**

**Prioritisation**

Our service prioritises referrals based on:

**Need** – including level of functional impact, risk factors for persistent difficulties, level of parental concern.

**Risk** – including significant social, emotional, and mental health concerns, safe-guarding concerns

**Timing** – including transition, education and health care plans.

**Team around the child** – including level of support required at home and within setting

**Episodes of care**

We currently follow an episode of care model. An Episode of Care will be different depending on the child’s needs at that time. We will assess the child. We will then work with the family and staff involved to help them to feel confident in supporting the child’s communication needs. The child will then be discharged with information about when and how to re-access the service. The time between each episode (a minimum of 8 weeks) should be used to follow the advice given and to practise the activities given by the speech and language therapy team.

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**Please note that we require parent/ carer consent for the referral & sharing of relevant information to have been discussed and obtained prior to completion of this form. we are unable to see children without this.**

**Information governance**

This form **may be** forwarded to speech & language by email to:

Fax-HPK.Admin-Hub@bdct.nhs.uk

but must be appropriately secured as it contains confidential /sensitive information.

Alternatively, fax 01274 215660

1. **Consent for referral to speech and language therapy**

|  |  |  |
| --- | --- | --- |
| **Please tick to confirm if you have discussed and gained consent for the following with parent/carer.** | **Yes** | **No** |
| **Referral to the Speech and Language Therapy Service** **(including, if appropriate, to assessment, treatment, and school visits):** |  |  |
| **Sharing of records with other health & education professionals:** |  |  |
| **Receiving SMS text appointments:** |  |  |

Please confirm that you, as the person with parental responsibility, consent to the referral to speech and language therapy for your child. Please also confirm you consent to the sharing of information with health and education professionals. You can find out more about how we collect, store, and share information at the following:

<https://www.bdct.nhs.uk/service-users-carers/your-health-records-data-protection/>

<https://www.bdct.nhs.uk/wp-content/uploads/2018/05/B-SLT-pdf.pdf>

**Parent / Carer signature:** ……………………………….……………………

**Date:**  ………………………………

1. **Parent / family details**

|  |  |
| --- | --- |
| **Parent name/s:** |  |
| **Parent’s main language:** |  |
| **Does the parent require an interpreter?** | Yes / No | **Preferred gender of interpreter:** | Male / Female / Either |
| **Family history of speech & language difficulties (please state diagnosis):** |  |

1. **Child’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Forename:** |  | **Surname****(family name):** |  |
| **Known as:** |  | **Gender:** |  |
| **Date of birth:** |  | **NHS number (if known):** |  |
| **Address:** |  |
| **Postcode:** |  | **Telephone No:** |  |
| **GP practice /****GP name:** |  | **Mobile No:** |  |
| **Religion:** |  | **Ethnic origin** |  |
| **Child’s main language:** |  | **Child’s other language/s:** |  |
| **Nursery:** |   | **Health visitor:** |   |
| **Medical diagnosis:** |  |
| **Other professionals involved e.g., paediatrician, audiology:** |  |

1. **Safeguarding and risk**

|  |
| --- |
| **Please state any relevant information relating to safeguarding and/or risk:** |
|  |

1. **Timing**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| **Is the child about to transition from one environment to another?****(e.g. nursery to primary e.g. primary to secondary)** |  |  |
| **Is the child currently under-going assessment for an education and health care plan?** |  |  |
| **Is there a need for input due to a significant change to the child’s EHCP through the annual review process?** |  |  |

1. **Reason/s for referral**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **Has the child received previous input from Speech & Language Therapy?** **If yes, provide the date on the child’s last report / mealtime guidelines below** |  |  |
|  |  |
| **Has the child’s eating and / or drinking changed since their last report?** **If yes, provide details of how below** |  |  |
|  |  |
| **Do the previous guidelines remain appropriate?** **If no, provide details of why not below** |  |  |
|  |  |
| **If this is a Health Visitor referral, has the Health Visitor observed this child eating?** **(If not, this referral may be rejected)****Please detail the advice given by the Health Visitor below** |  |  |
|  |  |
| **Please explain clearly what you are expecting the Speech & Language Therapy Service to provide** |
|  |

1. **Current eating and drinking regime**

|  |
| --- |
| **Type of Feeding** |
| **Gastrostomy Fed** | **Oral Feeding** |
| **Yes** |  | **No** |  | **Yes** |  | **No** |  |
| **Drink** |
| **Normal** | **Thickened** |
| **Yes** |  | **No** |  | **Yes** |  | **No** |  |
| **Food** |
| **Normal** | **Mashed** | **Pureed** |
| **Yes** |  | **No** |  | **Yes** |  | **No** |  | **Yes** |  | **No** |  |
| **Amount usually eaten** |
|  |

1. **Referrer’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer name:**  |  | **Referrer address:** |  |
| **Referrer role:** |  | **Referrer phone number:** |  |

**Referrer’s signature:** ……………………………….……………………

**Date:** ………………………………

**Please return completed form to:**

Fax-HPK.Admin-Hub@bdct.nhs.uk

Fax: 01274 215660