**Information Governance**

**Please email the completed form securely to** **admin.services@bdct.nhs.uk** **with the subject “SaLT Referral” or Fax to 01274 215660**

**Please call 01274 221166 with any queries.**

**Speech & Language Service**

Physical Health Administration Hub

New Mill

Victoria Road

Saltaire

BD18 3LD

Tel: 01274 221166

Fax: 01274 215660



**SPEECH and Language Therapy, Adult Community and Mental Health**

**Swallowing problems**

**Referral form**

**We triage referrals based on the information provided by you. Please complete ALL sections. We cannot accept a referral until we have a FULLY completed form.**

**Please sign to confirm you have read and understand this\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Personal information**  |
| **Surname** |  | **Title**  |       |
| **Forename(s)** |       | **Date of birth** |       |
| **Contact number** |       | **NHS number** |       |
| **Address** |       |
| Lives alone [ ]  Lives in Residential/ Nursing home[ ]  | Lives with       |
| **Carer** | No carer involved [ ]   |
| Carer’s name:       | Contact number:       |
| **Communication** | First language:       | Interpreter required? [ ] *Preferred gender? Male/Female* |
| **Outpatient appointments –** Held at Undercliffe Health Centre, BD2 4RA*Wheelchair accessible venue with free parking* | **Could the person attend a clinic appointment?***We may be able to see them sooner* | Yes [ ]  No [ ]   |
| **Referral information**  |
| **Primary medical diagnosis and relevant medical history (including surgery e.g. mouth, throat, stomach):** (*GPs - Please note that person summaries are* ***NOT*** *appropriate*)       |
| **Current medication** :      |
| **CONSENT**Has the person given their informed consent to this referral?  Yes [ ]  No [ ]  *If no, is it because the person lacks capacity to give their informed consent at this point in time? Yes [ ]  No [ ]  If so, please explain why this referral is considered to be in the person’s best interests:* **If the person has been assessed as lacking capacity to consent to this referral at this time, please ensure (where possible) their next of kin has been informed about this referral.** Name of person informed: Relationship: Contact number (if known):**Consent to share the patient record**We write our notes and reports on an electronic system called SystmOne which is shared by numerous healthcare professionals e.g GP, district nurse, dieticians. If you provide consent other healthcare professionals can see what we have recommended and we can contact them, if needed, as part of your care with us.**Can we share the person’s record with other healthcare people?** Yes, they have capacity [ ]  Yes, in best interests[ ]  No[ ]  |
| 1. **THE SWALLOWING PROBLEM**

**Does the person feed themselves?** Yes [ ]  Yes, with support [ ]   No, needs full support [ ]  Details:        |
| **Are they having problems with drinks?** **Are they having problems with food?** **What swallowing problems have you noticed?** **How often does the problem happen?****Has the person ever choked on food?** (*Choking is when the windpipe is blocked and they need back slaps or abdominal thrusts. It is a medical emergency. It is NOT the same as coughing***)****Have they had chest infections that needed antibiotics?****If yes, was it caused by aspiration?** (*food/drink going down the wrong way to the lungs*)**Has the person lost weight in the last 6 months?***If yes was it:* | Yes [ ]  No [ ]  Details:        Yes [ ]  No [ ]  Details:       e.g. meats, crumbly foods, bread[ ]  Coughing [ ]  Wet voice after swallowing [ ]  Eyes watering [ ]  Flushed (red) face Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Every meal/drink [ ]  Daily [ ]  Weekly [ ] Less often than weekly [ ]   Yes [ ]  A near miss [ ]  No [ ]  Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_At the moment or very recently [ ] Frequently – i.e. every 1 to 2 months [ ]  Occasionally [ ]  No [ ] Yes [ ]  No [ ]  Unsure [ ]  Yes [ ]  No [ ]  Suddenly in the last few weeks [ ] Gradually by a significant amount [ ]  |
| 1. **Other relevant information**

**Please add anything else you feel is relevant here:**      |
| Is this person on the palliative / fast track pathway?Have they been in hospital in the last 6 months? | Yes [ ]  No [ ]   Yes [ ]  No [ ] If yes, why:       |
| **Details of previous SLT input:**      If seen before:Are the recommendations still being followed? Yes [ ]  No [ ]  Are these recommendations still meeting their needs? Yes [ ]  No [ ]   |
|  |  |
| **Lone worker risk**Home visits are carried out by lone therapists. If you are aware of any risks presented by the **person’s** or **relative’s** behaviour or **within** or **around the person’s home**, please give details here. *Examples: Drug or alcohol misuse, mental health conditions that have led to previous violent incidents or other hazards.*Yes: [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No risks known[ ]   |
| **Referrer and GP details** |
| Date of referral:       |
| GP name:       | GP address:       |
| Contact number:       |
| **Referrer (if different to the GP)** |
| Name:       | Job title:       |
| Base:       | Contact number:       |
| **Is the GP aware of this referral?** Yes [ ]  No [ ]  Please note it is the referrer’s responsibility to ensure the GP is aware of this referral. |

**Appropriate Referral**

The following list gives some examples of appropriate referrals. This does not cover everything, so if you are still unsure whether your referral is appropriate, please contact SLT admin on 01274 221166 to discuss it before referring.

* Adults who have problems with eating, drinking and swallowing
* Adults who are frequently coughing specifically when eating or drinking
* Adults who have choked or had a choking near miss. This is *when the windpipe is blocked and back slaps or abdominal thrusts are needed. It is a medical emergency. It is NOT the same as coughing*.
* Adults who have frequent chest infections or pneumonia where aspiration (food, drink or saliva going down into the lungs) is suspected as the cause
* Weight loss connected with swallowing problems

**Inappropriate referral - We do NOT see:**

X People with reduced appetite who are refusing to eat and there are no concerns regarding swallowing

X People who are already on *safest consistencies* as further input is NOT indicated. PLEASE NOTE: “Safest” consistencies are Level 4 puree diet and Level 1 Slightly thick drinks/ Level 2 Mildly thick drinks/ Level 3 Moderately thick drinks

X People previously known to SALT who are managing on their previous recommendations. In these cases, further input is NOT indicated.

X People who have food pipe related swallowing problems i.e oesophageal dysmotility, achalasia. We only work with swallowing problems affecting the mouth and throat

X People who are on a modified diet only because of the condition of their teeth or dentures

X People who have capacity to make choices about their own health and have refused SALT input or chosen to not follow previous SALT recommendations