

Adult Speech and Language Service Professional Referral Form for Swallowing Difficulties

Date of referral……………………………………….

Any sections marked with an asterisk (\*) are mandatory. If they are not complete, the form will not be processed and will be returned to the referrer.

*Tick a minimum of one of the following boxes:*

\* The patient has consented to the referral. [ ]

 Or

 The patient lacks capacity and this referral is being made in their best interests: [ ]

Fully review the exclusion criteria below before completing the form.

|  |
| --- |
| PATIENT DETAILS \*Name: \*Patient telephone number: \*Date of Birth: NHS Number: \***Patient Address and Post Code:** \***Registered GP Practice:****Email Address (if available):****Interpreter Required: Yes** [ ]  **Language: Preferred Interpreter Gender:****Does the patient need help with appointment** e.g. wheelchair access, literacy, learning or mental health needs**:**  **Yes** [ ]  **Please give details:** **Is the patient considered to be in the last weeks/days of life? Yes** [ ]  **No** [ ]  |
| \*REFERRED BY  Name: Designation: Service: Tel. No.:  |
| EXCLUSION CRITERIA **The service is unable to accept referrals for individuals:** * under 18 or without a Barnsley GP.
* who are currently hospital inpatients *- contact the relevant inpatient service.*
* whose difficulties are the result of a learning disability / autism *- contact the Barnsley Adult Learning Disability Health Service.*
* whose difficulties result from a stroke within the last 6 months *- contact Barnsley Community Stroke Rehabilitation Team.*
* whose difficulties relates to ENT e.g. head and neck cancer, voice problems, vocal nodules, tracheostomy - *contact ENT services at Barnsley Hospital NHS Foundation Trust via their GP.*
* with mental health related swallowing difficulties, e.g. impulsivity / pica / eating non-food substances.
* who have difficulty swallowing tablets - *contact the GP or Pharmacist to discuss alternative ways of providing medication.*
* who have had a reduction in the amount of food and drink with a subsequent concern about hydration and nutrition - *consider a referral to the Community Dietetic Department and/or the GP.*
* who experience Nausea and/or vomiting after eating / drinking - *Contact the GP.*
* if the patient and / or family or carers not adhering to previous speech and language recommendations around diet and fluid modification.
* requesting a reassessment for the purpose of a pending review meeting.

**Additional Swallowing Exclusions for Care Home Residents:**Refer to ‘Feeding Safely Routines’ advice sheet embedded above.All of the above exclusions apply, as well as the following:* The patient is spitting out food with texture **-** *Consider softer options of diet using International Dysphagia Diet Standardisation Initiative (IDDSI) levels, downgrading to level 4, pureed diet, if necessary, with close monitoring.*
* The patient is having impulsive behaviours that are having an impact on swallowing e.g. large mouthfuls, eating/drinking on the move, rushing - *Ensure regular staff support throughout, gentle prompting to take smaller mouthfuls, a routine for oral intake and an environment with reduced distractions.*
* The patient pouches food and / or drink **-** *Give gentle verbal prompting to swallow, alternate food and drink (if this doesn’t cause coughing), consider softer options of diet using IDDSI levels but monitor closely as this may not help.*
* A one-off choking episode - *Supervise and monitor closely for further signs of difficult and refer if appropriate.*
* The person is coughing, choking or showing signs of discomfort on diet. - *Consider softer options of diet using International Dysphagia Diet Standardisation Initiative (IDDSI) levels, downgrading to level 4, pureed diet, if necessary, with close monitoring.*

If symptoms of swallowing difficulties persist, submit the referral form indicating the symptoms and actions already undertaken. |
| \***REASON FOR REFERRAL** *(please tick a minimum of one of the boxes listed for the reason for referral, failure to specify will result in the referral being rejected):*[ ]  Patient frequently coughing on fluids[ ]  Patient has a gurgly wet voice after eating and / or drinking[ ]  Patient coughs or chokes on diet despite following the advice within the Swallowing Exclusions above[ ]  Patient has recurrent chest infections. Provide dates: [ ]  Patient has significant discomfort when eating or drinking[ ]  Speech and Language recommendations have been implemented and the patient needs assessing due to an  improvement in swallowing **Additional Information (including if the patient is on a modified diet and or / fluids): …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………** |
| **SAFEGUARDING AND SAFETY CONCERNS including PREVENT:** **a) Are there any known safeguarding risks:** [ ]  **Yes** [ ]  **None Known** **If yes, tell us who will provide more information:**  Email Address (if available):**Name: Contact Details:** **b) Are there any known safety risks?** [ ]  **Yes** [ ]  **None Known**E.g. infectious conditions, such as cytomegalovirus (CMV), hepatitis, rubella, shingles, measles, Methicillin-resistant Staphylococcus aureus (MRSA), animals and pets, smoking and vaping in the home or risk of violence and aggression (including weapons in the home).**If yes, please tell us who will provide more information:** **Name: Contact Details:**  |
| **MEDICATION *(Please include details of any prescribed nutritional supplements):*** |
| **MEDICAL HISTORY** Does the Patient have any of the following (tick all that apply):

|  |  |
| --- | --- |
| Respiratory (Specify and give details in box below) | **[ ]**  |
| Dementia | **[ ]**  |
| Cancer (Specify and give details in box below) | **[ ]**  |
| Stroke | **[ ]**  |
| Motor Neurone Disease (MND) | **[ ]**  |
| Progressive Supranuclear Palsy (PSP) | **[ ]**  |
| Multi Systems Atrophy (MSA) | **[ ]**  |
| Parkinson’s Disease | **[ ]**  |
| Huntington’s Disease | **[ ]**  |
| Multiple Sclerosis (MS) | **[ ]**  |
| Frailty | **[ ]**  |
| Heart Condition | **[ ]**  |
| Brain Injury  | **[ ]**  |
| Reflux | **[ ]**  |
| Other (Specify and give details) | **[ ]**  |

 |