|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Name** | | | **Next of Kin, if known:** |  |
|  | | | (Relationship) |
| **NHS No.** | |  | **Home Tel No.** |  |
| **Home Address** | |  | **Mobile Tel No.** |  |
|  |  |  |
|  | **Preferred Contact**  (Carer/Neighbour etc.) |  |
|  |
| **Postcode** | |  |  |  |
| **Tel No.**  **Email address** | |  | **Tel No.** |  |
| **D.O.B.** |  | **Sex M  F** |  |  |
| **GP Surgery:** | | | | |
| **Does the patient attend their GP Surgery? Yes  No** | | | | |
| **Referrer’s Details**  Name:  Designation:  Date: | | | Telephone No:  Place of Work:  Signature: | |
| **Is the referral for:**  **Swallowing  Communication  Both** | | | | |
| **Has the patient consented to this referral?**  Yes  No  (referral will not be accepted) Lacks capacity, and referred in patient’s best interests | | | | |
| **Social Situation** *(e.g. Lives alone, carer responsibilities, current employment)* | | | | |
| **Medical History** *(please include relevant history e.g. Neurological diagnosis, COPD etc)* | | | | |
| Learning Disability: Yes  No | | | Dementia: Yes  No | |
| **Cognitive Status** | | | | |
| **COMMUNICATION**  Current: Speech  Gesture  Writing  Device  Please tick if any of the following are experienced/observed:  Difficulty understanding  Voice hoarse/quiet (ENT referral may be required)  Difficulty expressing self  Stammering  Slurring words | | | | |

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**SUFFOLK COMMUNITY SERVICES SPEECH AND LANGUAGE (SALT - 18+)**

**CARE CO-ORDINATION CENTRE REFERRAL FORM**

**Email:** [**suffolkcommunityhealthcare.referrals@nhs.net**](mailto:suffolkcommunityhealthcare.referrals@nhs.net)

**ALL FIELDS ARE MANDATORY Incomplete referral forms will be returned**

Patient Name………………………. NHS number/DOB………………………….

|  |
| --- |
| **What are your concerns about communication? What would you like us to do?**  E.g. Speech has deteriorated – reduce frustration and help person make choices  E.g. Old stroke and little opportunity for social interaction – consider for social communication group |
| **This box is for CARE HOMES ONLY - PLEASE READ BEFORE REFERRING FOR SWALLOWING.**  If your client has an ***eating and drinking difficulty*** (rather than a swallowing difficulty), you should refer to the **FRAMEWORK to Optimise Safer Eating and Drinking** and implement the guidance to see if this resolves the problem. If the problem has not resolved please continue to complete the referral form below.  Framework completed?  Yes  No  If yes, what difficulties are you still having |
| **SWALLOWING**  **Current fluids**: Thin (unthickened)  Level 1  Level 2  Level 3  Level 4  PEG  **Current diet**: Level 4 (Puree)  Level 5 (Minced & Moist)  Level 6 (Soft & bite sized)  Level 7 (Easy Chew)  Level 7 (Regular)  PEG  **Please tick if any of the following are experienced/observed:**  Coughing on drinking  Holding food/fluid in mouth  Coughing on eating  Problems chewing  Losing food/fluid from mouth  Feeling of food sticking – in throat? Yes  No  – in chest? Yes  No  **How often are these difficulties experienced/observed?**  With every meal  A few times a week  Occasionally  N/A |
| **What are your concerns about swallowing? What would you like us to do?**  E.g. Person has repeated chest infections – exclude aspiration  E.g. Person coughing on fluids – assess and advise on how they can drink safely or comfortably |
| **Has the individual experienced any chest infections in the last 6 months?** *(Care homes or GP’s making this referral must provide dates of any chest infections within the last 6 months and provide details of any antibiotics prescribed)*  Yes  No |
| **Any acute weight loss?** *(if yes, please provide extra details)*  Yes  No |
| **Any anxiety / distress / vulnerability?** *(if yes, please provide extra details)*  Yes  No |
| **Any further information?** |