|  |  |  |
| --- | --- | --- |
| **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**

**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 aspirationE.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?** |