

SUFFOLK COMMUNITY SERVICES SPEECH AND LANGUAGE



(SALT - 18+)

CARE CO-ORDINATION CENTRE REFERRAL FORM

Email: suffolk.ccc@esneft.nhs.uk

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

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

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:

- | | |
|---|---|
| <input type="checkbox"/> Coughing on drinking | <input type="checkbox"/> Holding food/fluid in mouth |
| <input type="checkbox"/> Coughing on eating | <input type="checkbox"/> Problems chewing |
| <input type="checkbox"/> Losing food/fluid from mouth | <input type="checkbox"/> Feeling of food sticking – in throat? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | – in chest? Yes <input type="checkbox"/> No <input type="checkbox"/> |

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?