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

Patient Name **NHS No.** **Home Address** **Postcode** **Tel No.** **Email address** **D.O.B.** **Sex M ☐ F ☐**	**Next of Kin, if known:** (Relationship) **Home Tel No.** **Mobile Tel No.** **Preferred Contact** (Carer/Neighbour etc.) **Tel No.**
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 ☐ Difficulty expressing self ☐ Slurring words	☐ Voice hoarse/quiet (ENT referral may be required) ☐ Stammering

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?