**Before completing this form ensure the individual meets the service criteria**

If the individual

* Is a child (excluding voice difficulties), refer to [C&F.ReferralCentre@lancashirecare.nhs.uk](mailto:C&F.ReferralCentre@lancashirecare.nhs.uk)
* Has a learning disability, refer to [LDReferralHub@lscft.nhs.uk](mailto:LDReferralHub@lscft.nhs.uk)
* Presents with dysfluency/stammering, refer to dysfluency service 01282 628359
* Presents with voice problems only, refer to ENT 01254 734554
* Is experiencing **swallowing difficulties specific to medication,** refer to relevant health professionals for guidance e.g., GP / Nurse Practitioner / Pharmacist
* Is experiencing swallow symptoms consistent with **gastro-intestinal (GI) difficulties,** refer to relevant health professionals for guidance e.g. GP / Gastroenterology
* Is experiencing **weight loss only,** monitor [MUST](https://www.bapen.org.uk/screening-and-must/must-calculator) scores & implement related strategies, including referral to local dietetic service if MUST score is 2 or more. See [BAPEN website](https://www.bapen.org.uk/) for MUST calculator & food fortification guidance

**If the individual is appropriate for the service, fill out this form with as much detail as possible**

All referrals will be triaged and prioritised upon receipt

**For referrals from care homes**, initial assessment will be completed by telephone during care home phone clinics. The assessing clinician will then arrange face-to-face follow-up if deemed necessary.

**INCOMPLETE REFERRALS WILL BE RETURNED TO THE REFERRER**

**Return by email or post:** [speechtherapycommunity.elht@nhs.net](mailto:speechtherapycommunity.elht@nhs.net)

Speech & Language Therapy Services, Rehabilitation Department, Area 7 Level 1, Burnley General Teaching Hospital, Casterton Avenue, Burnley, BB10 2PQ.

*If you do not receive an automated response from this email address to confirm receipt, please re-send/contact the office to discuss*

If unsure whether the referral is appropriate, contact us to discuss ☎: 01282 804 075

**Please note, we do not take referrals over the phone**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of referral:** | | | **Referrer name:** | | | | |
| **Referrer’s email address:** | | | **Referrer’s job role:** | | | | |
| **Patient Details** | | | | | | | |
| **Patient name:** | | | | | **Date of Birth:** | | |
| **Telephone number:** | | | | | **NHS number:** | | |
| **Address:**  **Floor/unit if care home resident:** | | | | | **Next of Kin:**  **Relationship to patient:**  **Telephone number:** | | |
| **Video assessment equipment available**  e.g., smartphone / laptop / tablet  **Yes No**  **Contact email:** | | | | | **GP name:**  **GP practice:** | | |
| **Diagnosis & medical history** | | | | | | | |
| **Is this patient anticipated to be in the final days or weeks of life? Yes No**  **If Yes, please detail:** i.e. Gold Standards Framework / Karnofsky / King’s staging | | | | | | | |
| **Allergies** | | | | | | | |
| **First language** | | | | **Interpreter required?**  **If yes, please specify dialect** | | | |
| **Known risks to staff** | | | | | | | |
| **Referral details** | | | | | | | |
| **Has the patient consented to the referral? Yes  No  Best interests** | | | | | | | |
| **Reason for referral Swallowing  Communication  Swallowing & Communication**  **Has the person been seen by SLT before? Yes  No**    **Is this a new episode of difficulty? Yes  No** | | | | | | | |
| **Swallowing (do not fill this section in if referral is for communication only)** | | | | | | | |
| **Current fluid consistency** | **Level 0**  Thin fluids | **Level 1**  Slightly thick | **Level 2**  Mildly thick | | **Level 3**  Moderately thick | **Level 4**  Extremely thick |  |
| **Current food consistency** | **Level 3**  Liquidised | **Level 4**  Pureed | **Level 5**  Minced and moist | | **Level 6**  Soft and bitesized | **Level 7 EC**  Regular easy chew | **Level 7**  Regular |
| **Detail any specific concerns or previous SLT advice regarding the swallowing of bread** | | | | | | | |
| **Coughing when eating**  Details (including frequency & severity) ………………………………………………………………………………………………………………………………….  **Coughing when drinking**  Details (including frequency & severity) ………………………………………………………………………………………………………………………………….  **Chest infections**  Details (whether active, within the last month or a recurrent pattern).  …………………………………………………………………………………………………………………………………..  **Significant choking episode(s)**  Detail date and time; what the individual choked on (food type, fluid type, saliva etc); any physical interventions/first aid required e.g. back slaps / abdominal thrusts; whether emergency services input required …………………………………………………………………………………………………………………………………..  …………………………………………………………………………………………………………………………………..  **Have any changes been made to eating/drinking management since the choking incident(s)?**  **Yes  No**  Details …………………………………………………………………………………………………………………………. | | | | | | | |
| **Assistance required with fluid/diet**  **Mouth-holding of fluid/diet**  **At risk of dehydration due to poor fluid intake**  Please detail daily average fluid intake………………. mls  **Weight loss**  *If weight loss observed monitor* [*MUST*](https://www.bapen.org.uk/screening-and-must/must-calculator) *scores & implement related strategies, including referral to local dietitian service if MUST score is 2 or more. See* [*BAPEN website*](https://www.bapen.org.uk/) *for MUST calculator & food fortification guidance.*  **Difficulties specific to swallowing medication**  *Refer to relevant health professionals for guidance if medication form or regime requires review*  *e.g.GP / Nurse Practitioner / Pharmacist* | | | | | | | |
| **Any additional details about swallowing, eating or drinking** | | | | | | | |
| **Communication (do not fill this section in if referral is for swallowing only)** | | | | | | | |
| **Does the person have:**  Difficulty understanding spoken language  Difficulty expressing information  Unclear speech  Voice problems | | | | | | | |
| **Any hearing impairment? Yes  No  Any visual impairment? Yes  No**  **Details** …………………………………………………………………………………………………………………………. | | | | | | | |
| **Any additional details eg. communication strategies, tools or aids already in use; impact on the individual** | | | | | | | |