**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
* Has a learning disability, refer to 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

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

**Return by email or post:** speechtherapycommunity.elht@nhs.net

Speech & Language Therapy Services, Area 1 Level 2, 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** |