

Speech and Language therapy Adult Community referral form

East Lancashire Hospitals
NHS Trust

Speech and Language therapy department
Area 1 Level 2
Burnley General Teaching Hospital
Casterton Avenue
Burnley
BB10 2PQ
Tel: 01282 804075

Please return by email/post

Email:- Speechtherapycommunity.elht@nhs.net

If you click SUBMIT at the bottom of the page this will populate an email to send to the above address
Click SAVE AS to save a copy/PRINT to print a copy or CLEAR to reset form and start a new referral.

Please fill out the form with as much detail as possible

INCOMPLETE REFERRALS WILL BE RETURNED TO THE REFERRER

All referrals will be triaged and prioritised upon receipt

Date of referral

| PERSONAL DETAILS | |
|---|---|
| Patient name | Date of birth |
| Home No. Mobile No. | NHS number |
| Address | Next of kin Relationship to patient |
| Floor/unit | Telephone number |
| Patient email (if applicable) | GP name/Practice |
| Diagnosis & Medical History | |
| Is this patient End of Life? Yes No If Yes, please detail ie)GSF/Karnofsky/Kings staging | |
| Allergies | |
| First language | Is an interpreter needed? Yes No If yes, specify language and dialect if applicable |
| Known risks to staff | |
| Has the patient consented to this referral? Yes No Best interests | |
| Does the patient have equipment to support video assessment? (ipad/laptop/smartphone?) Yes No | |
| REFERRAL DETAILS | |
| Reason for referral | |
| Has the person been seen by SLT before? Yes No If yes, specify where | |
| Is this a new episode of difficulty? Yes No | |

| | | | | | | |
|----------------------------------|------------------------------|---|--|--|---|---------------------------|
| Current Fluid consistency | Level 0 Thin | Level 1 Slightly thick 1 scoop | Level 2 Mildly thick 2 scoops | Level 3 Moderately thick 3 scoops | Level 4 Extremely thick 6 scoops | |
| Current Food consistency | Level 3 Liquidised | Level 4 Pureed | Level 5 Minced and moist | Level 6 Soft and bite sized | Level 7 EC Regular easy chew | Level 7 Regular |

Changes / new concerns regarding eating, drinking and swallowing skills:

If any of the below are ticked, please indicate frequency/severity

| | |
|---------------------------------------|--------------------------------------|
| Coughing when eating | Vomiting |
| Coughing when drinking | Temperature/fever |
| Chest infections | Mouth holding |
| Choking episodes | Unexplained weightloss |
| Difficulty when swallowing medication | (Refer to Medicines support team/GP) |

Dietitians involved Yes No

Any other information eg) level of assistance/delivery method of diet/fluids

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?

Other (please specify)

Dysfluency / stammering?

Please refer to Stammer service: 01282 628359)

Voice problems?

Please refer to ENT: 01254 734554)

Please give details of your concerns and the impact on the person:

Any hearing problems? Yes No Any visual problems? Yes No

Any other information: (if information exceeds 250 character count please continue overleaf)

Name of referrer

Job role

Referrer's email address

Click **submit** to send form to Speechtherapycommunity.elht@nhs.net
Alternatively send via post to the address on page 1 of the referral form

Additional information for referral: