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| East Sussex Speech and Language  Therapy Service for Adults    **Community Speech and Language Therapy (SALT) Adult**  **Referral Form**  **\*PLEASE NOTE\* this excludes:**   * **Mental health – where mental health is the primary diagnosis** * **Learning Disability** * **Congenital disorders** * **Developmental Dysfluency** * **Communication intervention for those with a diagnosis of dementia** * **Under 16s**   For Dysphagia – we accept referrals from any trained healthcare professional (e.g GP, nurse, dietitian).  For communication - we accept referrals from everyone including self-referrals.  Referrals should be sent via a secure email to:  [Esht.saltreferrals@nhs.net](mailto:Esht.saltreferrals@nhs.net)  **Please complete all questions below as the information will be used to triage the referral and assign a priority rating. If insufficient information is provided then this may result in the patient being triaged incorrectly or the form being returned for more information resulting in a delay for treatment. We aim to triage within 3-5 working days.**  For patient queries please contact the office on 0300 131 4541 (ESH) or 0300 131 4419 (H&R) | 2017-03-ESHT-logo-RGB |

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| **Patient Name:** | **Date of Birth:** |
|  | **NHS No:** |
| **Address:** | **GP address and contact number** |
| **Contact number:** | **Home situation. (Include any safe guarding issues.)** |
| **Next of Kin:**  **Contact number:** |
| **Medication:** | **Medical history:**  Assistive ventilation in place |
| **Has the patient consented to referral?**  Verbal  In Best Interests  Signed ………………………………………. | **Referral for:**  Communication  Swallowing |
| Communication Referrals **Communication impairment - Please tick**  Rapidly progressing  New communication impairment  with high impact on function  Chronic communication impairment with identified changes  Patient is frustrated or anxious  Other: please describe….. | **Is the patient able to co-operate with, and stay alert for, assessment?** |
| **Is patient confused, distractible or display signs of cognitive or memory impaired?** |
| |  | | --- | | **Patient name: NHS number:** | | **Can patient attend outpatients’ clinic?** Yes  No  **Can patient undertake assessment via video call?** Yes  No | | Swallowing referrals **Has the patient had a chest infection requiring antibiotics in the last three months:**  None  Once  More than once  **Does the patient cough or clear their throat:**  Every meal or drink  Once a day  Once a week or less  **Does the patient have a wet voice / shortness of breath / watery eyes:**  every meal or drink  Once a day  Once a week or less  **Is their condition likely to deteriorate:**  Rapidly (within 1 month)  Steadily (within 3 months)  Slow (over 6 months)  **Does the patient have trouble swallowing:**  Tablets  Saliva  **Are they losing weight/becoming dehydrated:**  Yes  No  **Are they anxious about their swallowing**  Yes  No  **Does the patient::**  Pouch food in their cheeks  Refuse or spit out food  **Has the patient’s swallow improved & possibly require more normal fluid or diet**  **textures?**  **Other:** please describe… | |  | | |
| **What food and drink textures does the patient currently take?**  **Fluids: Thin  Slightly thick - Level 1  Mildly thick - Level 2**  **Moderately thick - Level 3  Extremely thick – Level 4**  **Diet texture: Regular – Easy to chew  Soft & bite sized  Minced & moist**  **Pureed  Liquidised  NBM / PEG / NG**  **Any problem foods?..............................................................................................** | |
| **Please add any further information we should know about their communication, swallowing or general status.** | |

**Referred by (please print): ………………………………………… Date:** ……………………………

Signed: ……………………………………………..Job Title: ………………………………………..

Referrer’s contact details: ….……………………………………………………………………………….