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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**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?** |
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| **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… |
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| **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: ….……………………………………………………………………………….