**SPEECH & LANGUAGE THERAPY REFERRAL FORM FOR CARE HOME RESIDENTS**

**Date of referral:**

Please ensure all parts of the form are completed. Forms which are not adequately completed may be returned to the sender and may delay assessment or care for the resident.

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| --- | --- |
| **Resident’s name:** |  |
| **NHS number:**  |  |
| **Date of birth:** |  |
| **Current Address:****Post code:****Telephone Number:** |  |
| **Name of G.P.:****Name of Surgery:** |  |
| **If the resident is new to the home please give previous address:** |  |
| **Next of kin name and telephone number:** |  |
| **Referrer’s name and contact details:** |  |

|  |  |
| --- | --- |
| **Reason for referral:**  | Swallowing [ ]  Speech [ ]  Both [ ]   |
| **How long has the person had this problem?** |  |
| **Diagnosis and past medical history:** |  |
| **Has the resident had a chest / urine infection in the last 3 months? How many episodes?** | Yes No If yes, please give details; |

**For Swallowing Problems:**

**Is the resident known to Speech and Language Therapy?**  Yes [ ]  No [ ]

If yes, have there been any changes with swallow function? Yes [ ]  No [ ]

If there are no changes with swallow function, please refer to previous speech and language therapy recommendations. Referral to SLT is not required.

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| **Please give a description of the problem:** |  |
| **Have you taken any actions to help this problem?** | Yes [ ]  No [ ] If yes, please give details |

**How often does the problem occur?**

Every meal/drink [ ]  Daily [ ]  Several times/week [ ]

**Current consistency of fluids:**

Thin [ ]  Thickened [ ]

**Current type of diet:**

Regular [ ]  Easy to chew [ ]  Soft & Bite Sized [ ]  Pureed [ ]

**Does the patient feed themselves?**

Yes [ ]  No [ ]  Some help needed [ ]

**Does the resident have difficulties eating due to poor dentition only?**

Yes [ ]  No [ ]

If yes, a Speech and Language Therapy referral is not indicated. Try adjusting the diet consistency to make it easier to chew and refer to the dentist as appropriate for a review of teeth / dentures.

**Does the resident have problems taking medication?**

Yes [ ]  No [ ]

If resident has difficulties swallowing tablets only with no other swallowing difficulty please refer to pharmacy or to their GP for advice on medications. Referral to SLT is not required.

**Is resident holding food in mouth due to cognitive changes?**

Yes [ ]  No [ ]

If yes, holding food in the mouth can be a difficult symptom to manage however a referral to Speech and Language Therapy is not usually indicated.

**Is resident on end of life care pathway?** Yes [ ]  No [ ]

If yes - often in the last few days of life a person will lose interest in eating or drinking and they may be too drowsy to eat and drink. Efforts should be made to keep the person comfortable and regular mouth care is recommended. It is not appropriate at this stage to refer the resident for a Speech and Language Therapy assessment.

We will be happy to discuss any concerns over the telephone and we encourage you to refer to our policy document ‘Palliative Feeding for Comfort’ for further information. <https://www.buckinghamshireccg.nhs.uk/wp-content/uploads/2017/01/Palliative-Feeding-for-Comfort-Guideline.pdf>

**For communication problems:**

|  |  |
| --- | --- |
| **Please give a description of the problem**: |  |
| **What are your concerns and what would you like us to do?** E.g. speech has deteriorated, please assess for communication aid |  |

**Where possible we are happy to provide advice over the telephone or discuss cases to see if a referral is necessary. Please do not hesitate to contact our department for further information.**

**Please email the completed referral form to :** **buc-tr.adultsltreferrals@nhs.net**