**Speech & Language Service**

Physical Health Administration Hub

New Mill

Victoria Road

Saltaire, BD18 3LD

Tel: 01274 221166

**Email referrals to** [**Fax-HPK.Admin-Hub@bdct.nhs.uk**](mailto:Fax-HPK.Admin-Hub@bdct.nhs.uk)

**Subject “SALT Referral”**

[Speech and Language Therapy - adults - Bradford District Care NHS Foundation Trust](https://www.bdct.nhs.uk/our-services/community-health-services/speech-and-language-therapy-adults/)

**SPEECH AND LANGUAGE THERAPY ADULT COMMUNITY REFERRAL FORM: SWALLOWING & COMMUNICATION**

**NB: Incomplete forms will be returned**

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| **Please check first before completing our form- in case you need to refer to a different SLT service below:** | | |
| **Adults with communication/swallowing difficulties who have a diagnosis of a Learning Disability: Concerns are primarily in relation to their Learning Disability**. | **Adult Learning Disability Team**  Contact: Waddiloves Health Centre  01274 497 121. | |
| **Adults with communication/swallowing difficulties admitted to the Inpatient Mental health wards; Lynfield Mount Hospital and Airedale Centre for Mental Health.** | **Inpatient Mental Health Team**  Contact: Speech and Language Admin Hub:  01274 221166  E-referral on SystmOne | |
| **Adults with a stammer, if it is impacting on well-being**: including referrals for people with adult onset stammering that has been caused by recent onset neurological changes such as Functional Neurological Disorder, Stroke, Traumatic Brain Injury, and Parkinsons Disease | **Stammering Specialist Therapist**  Contact: Speech and Language Admin Hub:  01274 221166  E-referral on SystmOne | |
| **Adults with Voice Issues** | **Voice Specialist Therapist**   * Patients with a Voice Issue are required to have had a laryngeal examination within the last 12 months.   Please refer via GP to local ENT service if needed.   * If a laryngeal examination has taken place, please use the Voice Therapy Referral Form or refer via E-referral on SystmOne. | |
| **The following problems are NOT suitable for referral to our service:** | | |
| **Communication problem** | | **Services that may be able to help** |
| Adults with communication difficulties secondary to Autism who do not have a learning disability | | Contact local Autism services <http://www.specialistautismservices.org/our-services/> or the National Autistic Society <https://www.autism.org.uk/> |
| Adults who have had dyslexia since childhood | | Contact local adult dyslexia services or charities such as [www.dyslexiaaction.org.uk/](http://www.dyslexiaaction.org.uk/) |
| Adults with speech difficulties resulting from hearing loss | | Refer to Sensory Needs Team, Morley Street.  01274 435001 |
| Adults requiring input for confidence building, social skills, or public speaking | | Referrals for confidence building may be accepted in the mental heath service |
| Adults with childhood speech difficulties (e.g. lisps) who were discharged as children as optimum was reached. | | No current NHS provision |
| **Swallowing Problem** | | **Action required** |
| Person not following SLT advice and  a) Has capacity to make this decision or  b) GP/Medical team has agreed this is in their best interests | | Further SLT input is not indicated. Person’s wishes/best interest must be respected |
| Person already on safest possible consistencies of food and drink | | Further SLT input not indicated. GP/Medical team may consider enteral feeding |
| Person has food/drink with acknowledged risk of aspiration (Eating and Drinking at Risk (EDAR) /pragmatic feeding) | | Further SLT input not indicated at this stage  Please re-refer if the EDAR decision changes   * Individualised cases considered if full assessment and discussion not completed in acute setting, please provide full details below. |
| Difficulty swallowing tablets only | | GP/Pharmacist review |
| Low appetite or food/drink refusal with no concerns of swallowing difficulty | | GP/Dietician review |
| **Food pipe related swallowing problems** **only** (oesophageal dysmotility, achalasia) | | GP/Gastroenterology review |
| Difficulties chewing food due to condition of teeth / dentures only | | GP/Dentist review |
| Difficulties due to dry mouth / excess saliva / oral thrush only | | GP/Prescriber review |

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| **Consent** - **if this is not filled out correctly it will be returned to the sender** |
| Has the person given their informed consent to this referral?  Yes No |
| **Lack of capacity to consent:**  Does the person currently lack capacity to give informed consent? Yes No  If person lacks capacity has the next of kin been informed Yes No  Name of person informed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please explain why this referral is considered to be in the person’s best interests: |
| **Consent to Share Information** |
| **Can we share information with other healthcare services e.g. GP, district nurse, dietitians and contact them about the person’s care?**  Yes, with consent  Yes, best interests  No |

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| **Referrer and GP details** | |
| **Date of referral:** | |
| **GP name:** | **GP address:** |
| **GP Contact number:** |
| **Referrer (if not the GP)** | |
| **Name:** | **Job title:** |
| **Base:** | **Contact :** |
| Is the GP aware of this referral?Yes  No  Please note it is the referrer’s responsibility to ensure the GP is aware of this referral. | |

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| **Patient information** | | | | |
| **Surname** |  | | **Title** |  |
| **Forename(s)** |  | | **Date of birth** |  |
| **Contact number** |  | | **NHS number** |  |
| **Gender** | M F Non-Binary  Transgender Other Not disclosed | | | |
| **Preferred Pronoun** | He/him  She/her  They/them Other | | | |
| **Address** |  | | | |
| Lives alone | | Lives with: | |
| **Carer** | Yes No | | | |
| Carer’s name: | | Carer contact number: | |
| **Communication** | First language: | | Interpreter required? Yes No | |
| **Is the person Housebound?** | Yes No Detail: | | | |
| **Able to connect via video consultation?** | Yes  No  Detail: | | | |
| **Referral information** | | | | |
| **Primary medical diagnosis (e.g. Stroke, Parkinson’s Disease)**  **Is this person having an active mental health episode or under Psychiatry/ Older People’s Mental Health?** Yes No  **Relevant brief medical history (e.g. recent hospital admissions, surgery to mouth, throat)** (Please do not attach full patient summary)  **Is this person on the palliative/Fastrack pathway?** Yes No | | | | |
| **Specific Reason for referral e.g. new assessment of swallowing/communication, support with MCA Assessment** | | | | |
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| **Previous SLT input** | | | | |
| **When:** | | | | |
| **Reason and Outcome:** | | | | |
| **SWALLOWING (if no swallow concerns, please complete communication section below (GREEN)** | | | | |
| **Does the person:**  **Feed themselves?** Independently  With support  Fully supported | | | | |
| **Have problems with drinks?** Yes No  Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Have problems with food?** Yes No  Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **What signs of aspiration have you noticed?**  Coughing  Wet voice  Eye watering  Red face    **How often does this happen?**  Every meal/drink  Daily  Weekly  Infrequently  **Has the person choked on food i.e. when the windpipe is blocked requiring back slaps or abdominal thrusts?****(Different to coughing)**  Yes  Near miss  No  **If yes / near miss please give details e.g. how many times, what with?** | | | | |
| **Has the person had chest infections requiring antibiotics?** Yes No  **If yes, is aspiration a suspected cause**? Yes No **How often does this happen?**  Recently Frequently Occasionally | | | | |
| **Weight** | | | | |
| **Has the person lost weight in last 6 months?** Yes No  **If yes, is the weight loss** Gradual significant amount Minimal  **Are swallowing problems the suspected cause?** Yes No Not sure | | | | |
| **Other concerns** | | | | |
| **Positioning: When eating/drinking does the person struggle to sit upright? (e.g. hold their head up?**) Yes  No  Details: | | | | |
| **Has the person had previous SALT input?** Yes  No  Unsure | | | | |
| **IF YES** – What is the existing SLT advice?  **DRINKS**  ☐ Normal drinks (no thickener)  ☐ IDDSI Level 1 Slightly thick  ☐ IDDSI Level 2 Mildly thick  ☐ IDDSI Level 3 Moderately thick  ☐ IDDSI Level 4 Extremely thick | | **FOOD**  ☐ IDDSI Level 7 Regular diet  ☐ IDDSI Level 7 Easy Chew  ☐ IDDSI Level 6 Soft and bite size  ☐ IDDSI Level 5 Minced and Moist  ☐ IDDSI Level 4 Puree  ☐ IDDSI Level 3 Liquidised | | |
| **Is the person following their plan/advice?** Yes  No | | | | |
| **COMMUNICATION**  **Does the person:** | | | | |
| **Have problems understanding what is being said to them?** Yes  No  Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Have slurred or unclear speech?** Yes  No  Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Jumble words up?** Yes  No  Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Have problems choosing words or making sentences?** Yes  No  Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Have problems reading & writing associated with their diagnosis?** Yes  No  (i.e. not pre-existing)?  Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Does the person gesture, point or use a communication aid to be understood?**  Yes  No  Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Can the person be understood by:**  Everyone  Familiar people only  Nobody  **Does the communication problem prevent the person from going about their daily life?** Yes  No | | | | |
| **ANY OTHER INFORMATION:** | | | | |

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