**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**

**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 221166E-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.
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| **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 anda) 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 stagePlease 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.
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| 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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