Shape

Description automatically generated with medium confidence

**Hull and East Riding Adult Speech and Language Therapy Service**

**Referral Form**

**\*Please Note: Incomplete forms will be returned resulting in delayed assessment\***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name of Referrer: | | | | | | | | | Date of Referral: | | | | | | | |
| Job Title: | | | | | | | | | | | | | | | | |
| Address & contact number/email: | | | | | | | | | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | | |
| Registered GP: | | | | | | | | | | | GP Practice Address: | | | | | |
| Telephone Number: | | | | | | | | | | |
| Title: | Forename: | | | | | | | | | | Surname: | | | | | Known as: |
| Date of Birth: | | | | | | | | | | | NHS Number: | | | | | |
| Gender: | | | | | | | | | | | Ethnicity: | | | | | |
| Religion: | | | | | |
| Address: | | | | | | | | | | | | | | | | |
| Patient Home Telephone Number: | | | | | | | | Patient Mobile Number: | | | | | | | | |
| Preferred contact number: Home  Mobile | | | | | | | | Email address: | | | | | | | | |
| Lives alone/carers/nursing home/  residential home: | | | | | | | | Next of Kin/Carer/Emergency contact: | | | | | | | | |
| Consent to contact via SMS | | | | | | | | | | | Yes | | | | No | |
| Consent to contact via SMS & Email | | | | | | | | | | | Yes | | | | No | |
| Translator required: | | Yes | | | No | | | | | Language required: | | | | | | |
| Accessible information needs: | | Yes | | | No | | | | | Detail needs: | | | | | | |
| Diagnosis: | | Client aware of diagnosis? | | | | | | | | | | Yes | | No | | |
| **SUPPORTING INFORMATION** | | | | | | | | | | | | | | | | |
| Is there a Lone working risk? | | | | | | | | | | | Yes | | | | No | |
| Is there a Safeguarding risk? | | | | | | | | | | | Yes | | | | No | |
| Has the patient given consent for the referral? | | | | | | | | | | | Yes | | | | No | |
| Any concerns re Mental Capacity? | | | | | | | | | | | Yes | | | | No | |
| **ReSPECT** document in place? | | | Yes | | | No | | | | | **(If yes give details)** | | | | | |
| Smoking: | | | Yes | | | No | | | | | Don’t know | | | | | |
| **MEDICAL HISTORY** | | | | | | | | | | | | | | | | |
| **(Include any relevant history, issues with hearing, vision, memory or attach medical history summary, neurology or ENT reports etc):**  **The following information will be used to prioritise swallowing referrals received –** (Please ensure accurate responses to the questions below or there may be a delay in processing the referral) | | | | | | | | | | | | | | | | |
| Ongoing or recurrent chest infections | | | | | | | | | | | Yes | | | | No | |
| High risk of dehydration/malnutrition - **Please consider referral to Dietetics service if concerns regarding significant weight loss.** | | | | | | | | | | | Yes | | | | No | |
| Rapidly deteriorating or receiving end of life care | | | | | | | | | | | Yes | | | | No | |
| History of choking episodes requiring back slaps / abdominal thrusts | | | | | | | | | | | Yes | | | | No | |
| **Please note choking occurs due to obstruction of a solid bolus, which causes inability to breathe. Please do not tick this box if only coughing is observed, or no intervention e.g. back slaps required.** | | | | | | | | | | | | | | | | |
| **SOCIAL INFORMATION** | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **REASON FOR REFERRAL** | | | | | | | | | | | | | | | | |
| **Communication ?** | | | | Yes | | | | | | | | | No | | | |
| **(Please provide information regarding speech or language difficulties observed e.g. word finding difficulties, slurred speech, stammer, voice changes. Please note voice referrals can only be accepted with a recent ENT report attached).** | | | | | | | | | | | | | | | | |
| **Swallowing?** | | | | Yes | | | | | | | | | No | | | |
| **Any previous SLT involvement/recommendations in place?** | | | | | | | Yes | | | No | | **(If yes give details)** | | | | |
| **Current intake:**  Difficulties or concerns noted: | | | | | | | | | | | | | | | | |
| Coughing on: fluids | | | | Yes | | | | | | | | | No | | | |
| Coughing on: solids | | | | Yes | | | | | | | | | No | | | |
| Reduced intake: fluids | | | | Yes | | | | | | | | | No | | | |
| Reduced intake: solids | | | | Yes | | | | | | | | | No | | | |
| **Please send by email to:** [**chcp.247111@nhs.net**](mailto:CHCP.247111@nhs.net) **or contact Tel – 01482 247111**  **Exclusions:**   * GP not a Hull or East Riding GP * Younger than 18 years * Difficulties related to confirmed learning disability (refer to Community Team for Learning Disabilities) * Voice difficulties and live in Hull (refer to SLT Team at Hull Royal Infirmary) * Speech or swallowing disorders due to head and neck cancer (refer to SLT Team at Hull Royal Infirmary) * New diagnosis of stroke (refer to Hull Integrated Stroke Service) * Patient with oesophageal level swallowing difficulties only (may require gastroenterology referral) * Difficulties only with swallowing medication (refer to GP / pharmacist as indicated) * **Referrals must be signed by a registered health/ social care professional or care home manager/ deputy.** | | | | | | | | | | | | | | | | |

\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***