

# Speech & Language Therapy: Referral Form for Care Home and Hospice Residents



Please note this form must be completed in FULL.

<p><b>Resident being Referred</b></p> <p>Name: Date of Birth: CHI:</p>	<p><b>Care Home/Hospice Details</b></p> <p>Care Home/Hospice Name: Unit Name/Floor: Address: Tel: Phone extension: Bed type (Please select):    <input type="checkbox"/> Permanent    <input type="checkbox"/> Respite        <input type="checkbox"/> Discharge to Assess</p>
<p><b>GP:</b></p> <p>Address:  Tel:</p>	<p><b>Referrer Information</b></p> <p>Print Name: Job Title: Contact details:</p>
<p><b>Date of Referral:</b></p> <p><b>Referral reason:</b></p> <p>If your referral is for swallowing, please consult Swallowing Matters before completing this referral form.</p> <p><input type="checkbox"/> Swallowing <input type="checkbox"/> Communication</p> <p>*If communication referral please answer below:</p> <ul style="list-style-type: none"> <li>• Have there been changes to the person's speech or communication? Please detail these:</li> <li>• Does the person have a communication aid? Please supply details:</li> <li>• How distressed is the person by their communication issue?</li> </ul>	<p><b>Reason for swallowing referral (please tick):</b></p> <p><input type="checkbox"/> Suspected / recurrent chest infection <input type="checkbox"/> Choking incident (requiring first aid) <input type="checkbox"/> General deterioration e.g. UTI / general decline <input type="checkbox"/> Coughing when eating / drinking <input type="checkbox"/> Review for upgrade of diet / fluids (improvement); <input type="checkbox"/> New neurological event e.g. TIA / Stroke; <input type="checkbox"/> New neurological diagnosis e.g. PD / MND <input type="checkbox"/> Refusal of texture modified diet / fluids <input type="checkbox"/> Other _____</p> <p>If you are concerned about any of the following, please refer to Swallowing Matters:</p> <ul style="list-style-type: none"> <li>• Unable to swallow medication</li> <li>• Vomiting / regurgitation</li> <li>• Holding food in mouth due to cognitive changes, but no other swallowing difficulty</li> <li>• Spitting out particles of food</li> <li>• Too drowsy to manage sufficient oral intake</li> <li>• Person is approaching EOL (End of Life)</li> </ul>

### **Past Medical History:**

Any recent changes to function e.g. deterioration in Dementia, recent hospital admission etc.?

### **Does the resident have capacity?**

Yes     No

If no capacity is one of the following in place?  
(Please tick all that apply)

- AWI (section 47)
- Welfare POA/Guardianship

**Name of welfare POA & contact details:**

**Has resident or welfare POA given consent for this referral:**

Yes     No

**Consent must be gained before the referral is submitted.**

**If no POA - NOK Name & contact details:**

### **Description of problem**

**Note** – please comment on who is concerned; level of concern; any witnessed difficulties e.g. pocketing of food; occasional or frequent coughing; significant episodes of choking resulting in airway obstruction and first aid/assistance required.

If the person is having issues with diet please give examples e.g. harder foods; chewy meats; diet 'with bits in it'

Have you put precautions in place whilst you await SLT swallowing assessment for this person? E.g. a different IDDSI level of diet; supporting the person with eating / drinking. Please give details:

## Food and fluid information (please tick):

<b>Fluids</b> Delivery of fluids by: <input type="checkbox"/> Normal Cup <input type="checkbox"/> Spouted Beaker <input type="checkbox"/> Volume Control Cup <input type="checkbox"/> Teaspoon	(Please mark with X)	
	Previously managing	Precautions initiated by referrer
LEVEL 0 (NORMAL) FLUIDS		
LEVEL 1 FLUIDS		
LEVEL 2 FLUIDS		
LEVEL 3 FLUIDS		
LEVEL 4 FLUIDS		
<b>Diet</b> Level of Assistance Required when eating: <input type="checkbox"/> Independent <input type="checkbox"/> Supervised <input type="checkbox"/> Requires Prompts <input type="checkbox"/> Full Assistance	(Please mark with X)	
	Usual consistency	Changes made by the care staff (if any)
LEVEL 7 REGULAR		
LEVEL 7 EASY TO CHEW		
LEVEL 6 SOFT AND BITE SIZED		
LEVEL 5 MINCED AND MOIST		
LEVEL 4 PUREED		
LEVEL 3 LIQUIDISED		

<p><b>Return Completed Form by secure E-mail to:</b></p> <p>✉ <a href="mailto:ggc.sltcarehome.referrals@nhs.scot">ggc.sltcarehome.referrals@nhs.scot</a></p>
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\*Please note if you are in any way unsure about placing a referral or you would like to discuss your patient with a member of the SLT team please contact the department on ☎ 0141 232 9222.\*

