**ADULT SPEECH AND LANGUAGE THERAPY DEPARTMENT**

**Swallowing difficulties referral form**

**This referral form will only be accepted if all of the following information is supplied.**

**GP/ Surgery:**

**Name & address:**

**DOB:**

**NHS number:**

**Phone number:**

**GP/Surgery:**

**Medical Diagnosis:**

**Food and fluid textures currently taken:**

Regular (Level 7) **□** Thin fluids (Level 0) **□**

Regular Easy to Eat **□** Slightly thick fluids (Level 1) **□**

Soft and Bite-Sized (Level 6) **□** Mildly thick fluids (Level 2) **□**

Minced and Moist (Level 5) **□** Moderately thick fluids (Level 3) **□**

Pureed (Level 4) **□** Extremely thick (Level 4) **□**

**Current strategies being used:**

**Recent unintentional weight loss?** No Yes How much \_\_\_\_\_\_\_

**DYSPHAGIA SYMPTOMS / REASON FOR REFERRAL**

**Has their swallow improved?** No Yes Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Coughing with fluid?** No Yes How often \_\_\_\_\_\_\_

**Coughing with food?**  No Yes How often \_\_\_\_\_\_\_

**Choking (i.e. occlusion of airway)?** No Yes How often \_\_\_\_\_\_\_

**Chest infections?**  No Yes How often \_\_\_\_\_\_\_

**Effortful swallowing**  No Yes How often \_\_\_\_\_\_

*(Excludes oral holding – for advice on this please call the booking office on 01249 456448 and they will arrange for a member of staff to call you to discuss).*

*Please note we are now a digital first service and will try to support via video or telephone in the first instance. A limited number of outpatient appointments are available. Home visits are reserved for circumstances where remote support cannot be facilitated.*

**Referrer details:**

Name: Profession:

(If a nursing home, manager’s signature required)

Address:

Contact telephone number: Date completed:

***Please email referral to :***

whc.sltreferrals@nhs.net