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**CHILDREN’S SPEECH AND LANGUAGE THERAPY**

**FEEDING REFERRAL FORM**

**FOR COMPLETION BY PROFESSIONALS**

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| **BEFORE PROCEEDING WITH THIS REFERRAL –**   1. **REFERRAL FOR BABIES/CHILDREN WHERE THERE IS CONCERN ABOUT SAFETY OF SWALLOW AND/OR ORAL-MOTOR FEEDING DIFFICULTIES, OR CHILDREN UNDER 18 MONTHS WITH SENSORY-AVERSIVE FEEDING ISSUES – SEE CSLT DYSPHAGIA THRESHOLDS DOCUMENT FOR FURTHER INFORMATION. THE GUIDELINES CAN BE LOCATED IN THE FEEDING DIFFICULTIES SECTION OF OUR WEBSITE AT:** [**www.leedscommunityhealthcare.nhs.uk/cslt**](http://www.leedscommunityhealthcare.nhs.uk/cslt) 2. **LEEDS COMMUNITY HEALTHCARE PROFESSIONALS SHOULD ACCESS REFERRAL FORM VIA SYSTMONE** 3. **ALL OTHER PROFESSIONALS SHOULD COMPLETE REFERRAL AS BELOW AND EMAIL THE FORM TO: lcht.slt.leedsreferrals@nhs.net** 4. **IF YOU ARE UNSURE WHETHER THIS REFERRAL IS APPROPRIATE, PLEASE CALL 0113 843 2760 TO DISCUSS WITH KIRSTY WALLACE (CLINICAL LEAD) OR E-MAIL kirsty.wallace6@nhs.net** |

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| **PLEASE NOTE THAT WE REQUIRE PARENT/CARER CONSENT FOR THIS REFERRAL** | | | | |
| **PARENT/CARER CONSENT DISCUSSED AND OBTAINED:** | **YES** |  | **DATE** |  |
| **PARENT/CARER CONSENT TO RECEIVE SMS TEXT APPOINTMENT REMINDER MESSAGES:** | **YES** |  | **NO** |  |

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| **DETAILS OF CHILD BEING REFERRED:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FIRST NAME:** | | | |  | | | | | | | | | | | | | | | | | **SURNAME:** | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **NHS NO:** | |  | | | | | | | | | | | | | | | **DOB:** | |  | | | | | | | | | | | | **GENDER:** | | | | | | | | |  | | | | | | | |
| **ADDRESS:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | **POSTCODE:** | | | | | | | | | | |  | | | | | | | | | | | | |
| **CONTACT TEL NOs:** | | | | | | **HOME:** | | | | | | |  | | | | | | | | | **MOBILE:** | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **PARENT/CARER NAME(S):** | | | | | | | | |  | | | | | | | | | | | | | | | | | | **RELATIONSHIP:** | | | | | | | | | | |  | | | | | | | | | |
| **GP NAME/PRACTICE:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **GP ADDRESS:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **GP TEL NO:** | | | | | |  | | | | | | | | |
| **HV / SCHOOL NURSE NAME:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HV / SCHOOL NURSE BASE:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **TEL NO:** | | | | | |  | | | | | | | | |
| **OTHER AGENCIES/ PROFESSIONALS INVOLVED? PLEASE SPECIFY:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DOES THE CHILD ATTEND A SETTING EG SCHOOL, NURSERY, CHILDREN’S CENTRE?**  **IF YES, PLEASE GIVE DETAILS BELOW:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **YES** | | | | | |  | | **NO** | | |  |
| **SETTING NAME:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SETTING ADDRESS:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SETTING TEL NO:** | | | | |  | | | | | | | | | | | | | | | | **KEY WORKER NAME:** | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| **DAYS WHEN CHILD ATTENDS SETTING:** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DETAILS OF ANY PREVIOUS SLT INVOLVEMENT. PLEASE SPECIFY:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **KNOWN DIAGNOSED MEDICAL CONDITIONS/**  **MEDICAL ISSUES. PLEASE SPECIFY:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CURRENT MEDICATION.**  **PLEASE SPECIFY:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ARE THERE ANY CONCERNS ABOUT GROWTH** | | | | | | | | **YES** | | | |  | | | | **IF YES, PLEASE SPECIFY:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NO** | | | |  | | | |
| **LANGUAGE(S) SPOKEN AT HOME:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IS AN INTERPRETER REQUIRED?** | | | | | | | | | | **FOR PARENT/CARER** | | | | | | | | **YES** | |  | | | **NO** | |  | | | | **FOR CHILD** | | | | | | | | **YES** | | | | | |  | | **NO** | |  |
| **If YES – PLEASE INCLUDE SPECIFIC REQUIREMENTS EG GENDER OF INTERPRETER, WHICH LANGUAGE/DIALECT:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ARE THERE ANY SAFEGUARDING CONCERNS REGARDING THIS CHILD/FAMILY?**  **IF YES, SLT WILL CONTACT REFERRER** | | | | | | | | | | | | | | | | | | | | | | | | | | **YES** | | | |  | | | | **NO** | |  | | | | | **NOT KNOWN** | | | | |  | |
| **REASON FOR FEEDING REFERRAL AND ADVICE GIVEN SO FAR:**  **Please read referral guidelines over leaf before making your referral.** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PARENT/CARER VIEWS:** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **For Health Professionals Only: MOST RECENT DEVELOPMENTAL CHECK INFORMATION:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DATE:** |  | | | | | | **RESULT:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **DETAILS OF MEDICAL CONSENT (Consent can be verbal eg on phone)** | | | |
| **MEDICAL PRACTITIONER:** |  | | |
| **TITLE:** |  | | |
| **BASE:** |  | | |
| **E-MAIL:** |  | | |
| **TELEPHONE NUMBER:** |  | | |
| **DATE CONSENT OBTAINED:** |  | **NB PAEDIATRICIANS ONLY:** Do you give consent for VFSS referral if needed? | **Yes/ No** |

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| **DETAILS OF REFERRER:** | |
| **NAME:** |  |
| **DESIGNATION:** |  |
| **BASE:** |  |
| **E-MAIL:** |  |
| **TELEPHONE NUMBER:** |  |
| **DATE:** |  |

**LEEDS COMMUNITY HEALTHCARE STAFF SHOULD COMPLETE THIS REFERRAL FORM VIA SYSTMONE AND TASK TO:**

**ADMINISTRATION, LEEDS COMMUNITY CHILDREN’S SPEECH AND LANGUAGE SERVICE**

**ALL OTHER AGENCIES SHOULD COMPLETE THE FORM AND SEND TO:**

**CHILDREN’S SPEECH AND LANGUAGE THERAPY ADMIN SERVICE**

**Leeds Community Healthcare,**

**Building 3 White Rose Park**

**Millshaw Park Lane**

**Leeds**

**LS11 0DL**

**Or Email: lcht.slt.leedsreferrals@nhs.net**

**IF YOU HAVE ANY QUERIES PLEASE CONTACT THE CHILDREN’S SPEECH AND LANGUAGE THERAPY ADMIN TEAM -**

**TEL: LEEDS (0113) 843 3650.**

**WE WILL CONTACT YOU IF THIS REFERRAL FORM IS NOT FULLY COMPLETED AND/OR WE REQUIRE MORE DETAIL.**

**PLEASE NOTE WE AIM TO OFFER INITIAL APPOINTMENTS WITHIN 4 WEEKS OF THE CHILDREN’S SLT SERVICE RECEIVING THIS REFERRAL.**

**Children’s Speech and Language Therapy Service**

Dysphagia/Feeding and Swallowing in Children

**Who we see?**

The CSLT CFT/ dysphagia team will see infants and children with feeding and swallowing difficulties (dysphagia) who fall into the following categories

1. Concern about swallow safety/aspiration, and/or significant oral motor delay/disorder affecting ability to manage food bolus
2. Children up to 18 months who have sensory aversive responses to food/fluid/touch around mouth

**If you are not sure whether to refer:**

1. Find out as much as you can by asking questions about
   1. Onset of the problem and feeding history
   2. Typical day’s intake – textures/types of food/drinks and rough amounts
   3. How long the mealtime takes
   4. Pattern of growth
   5. Any sensory problems eg. reluctance to have teeth brushed/get messy
   6. Health – esp. any chest infections.
2. Observe the child having food/drink
   1. Are sucking, biting, chewing skills (oral motor) appropriate for age/ delayed/ unusual?
   2. Does food/drink re-emerge?
   3. Are there any signs of aspiration/unsafe swallow?
   4. How keen is the child to eat/drink

**If observation shows any of the following:**

* Signs of aspiration eg frequent coughing/spluttering/gagging/choking, history of chest infections; wet, “ruttly” sounding breath or voice; colour changes to skin, lip, nail beds; breathlessness; eye watering; grimacing, /rapid blinking/pulling back
* Clear oro-motor feeding difficulties such that child cannot suck/bite/chew etc at level appropriate for age
* Sensory-aversive behaviours around food/drink in a child under 18 months

**refer the child to the Community Feeding Team**

**If observations show any of the following:**

* Food refusal/picky eating/rigid food behaviours/restricted intake due to choices
* Emotional/behavioural issues around food and mealtimes
* Lack of awareness of or response to child’s cues by feeder (eg force feeding)
* Mild delay in moving through textures

refer the child to **local health visitor** for further observation/advice and for consideration of onward referral (eg to Paediatrician/Growth and Nutrition Team)

**We do not accept referrals related to the following:**

* **Children who have had a one-off choking episode and are now displaying food aversion/ avoidance or fear of choking.**
* **Children who have a diagnosis of Autism/ suspected Autism where the feeding difficulties are related to sensory differences regarding food texture/ taste/ smell- in these instances please sign post parents/ carers to the following webinar:** [Supporting your child with feeding - YouTube](https://www.youtube.com/watch?v=Jn5ezTXF_Z4) **and/ or the Mindmate hub** [Eating and food - MindMate](https://mindmate.org.uk/nd/living-nd/eating-nd/)

**Please see next page for further information on appropriate referral routes**

If you have any doubts ring the Community Feeding Team - 0113 8432760

Sensory aversive behaviours around food/

mouth area in children under 18 months

Social/emotional/behavioural reasons or restricted food choices (but not textures) ONLY, or sensory aversive issues in older toddlers/children

Doctor/

H. Visitor to advise/monitor or refer on to appropriate services eg Growth and Nutrition team

O.T. referral

H.V. or local SLT to Monitor & advise

Refer to Medic

Indications of Reflux

Difficulties with using utensils

Mild delay in Oral Motor feeding skills

Lack of previous experience or not enough time to adjust to new textures

Clear Oral-motor feeding difficulties

(ie. child cannot suck/swallow/bite/

chew at level expected for age)

If no change after advice implemented

**Signs of Aspiration:**

eg. -

- grimacing/blinking

- change in breath or voice

during feeding

- repeated chest infections

- frequent gag/cough/

choke on food or liquids

**Refer to SLT Specialist in feeding and swallowing**