**A close-up of a logo

Description automatically generatedReferral to the Speech and Swallowing Team**

The Speech and Swallowing Team meets the needs of adults (aged 18+) who present with

acquired communication and/or swallowing difficulties.

Please note this referral form is for the **Adult Community SLT** service only.

**We accept referrals from all registered health and social care staff**

Patients referred to us must be registered with a Leeds GP.

The Speech & Swallowing Team is commissioned to provide a service for the following patient groups (with a swallowing or communication need):

* Neurological
* Frailty
* Respiratory
* End of life

Please take the time to complete all relevant sections as incomplete referrals will not be accepted and will be returned to the referrer.

**Please answer the following questions before considering a referral to our service.**

*If this section is not completed, your referral will not be accepted.*

|  |  |  |
| --- | --- | --- |
| Does the patient have a swallow or communication impairment and a diagnosed Learning Disability which makes it difficult for them to benefit from non-specialist services? | Yes  No | If yes – Please refer to the Community Learning Disability Team (Leeds and York Partnership Foundation Trust).  To make a referral by email, please download, complete and return [CLDT Referral Form (updated august 2021)](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.leedsandyorkpft.nhs.uk%2Fcontact-us%2Fwp-content%2Fuploads%2Fsites%2F9%2F2021%2F10%2FCLDT-Referral-Form-updated-august-2021.docx&data=05%7C02%7Cd.wilson14%40nhs.net%7C9bd48a6f690b4e9dd79b08dd1602cb8b%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638690923432316057%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=p3Me4gJAtfL1bjpiVHocJNJCm4NlyR%2Fv%2BP%2BkiHS0qPs%3D&reserved=0) and send to [referral.lypft@nhs.net](mailto:referral.lypft@nhs.net) |
| Does the patient have a communication impairment as a result of their diagnosis of Autism? | Yes  No | If yes - SLT interventions for this client group will only be effective when provided within a multi-disciplinary team.  This model of service is not currently commissioned in Leeds.  The National Autistic Society: <https://www.autism.org.uk/> |
| Does the patient have a diagnosis of head & neck cancer? | Yes  No | If yes – a GP referral should be completed to the Leeds Oncology Speech and Language Therapy Team. Referrals should be sent to [leedsth-tr.LeedsHNRehab@nhs.net](mailto:leedsth-tr.LeedsHNRehab@nhs.net) |
| Is the reason for referral stammering or dysfluency? | Yes  No | If yes – please refer to the Stammering Support Centre.  Self-referrals are encouraged via this link: [LCH SLT Contact and Referral](https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/speech-and-language-therapy2/contact-and-referral-details/) |
| Is the reason for the referral due to a voice problem (not related to Parkinson’s)? | Yes  No | If yes – there is a specialist SLT service within the ENT team who provide a service for this patient group.  If the patient has not been seen by ENT in the last 6 months, please consider a GP referral to ENT for further investigations. |
| Is the reason for the referral due to reflux?  E.g. Dry mouth or throat, globus (feeling of lump in throat), throat clearing, hoarse voice, dry cough after eating and through the night, nausea, heartburn/chest pain or indigestion | Yes  No | If yes - Liaise with GP for reflux medication or refer to gastroenterology if symptoms persist. |
| Is the reason for the referral due to oesophageal difficulties?  E.g. the feeling of food sticking in the oesophagus and/or pain when swallowing (in the chest area), regurgitation of food and/or drink | Yes  No | If yes - SLT assessment and intervention is not indicated for isolated oesophageal stage difficulties. You may wish to consider a GP referral to gastroenterology for further assessment and treatment. |
| Is the reason for the referral due to difficulties associated with a mental health condition with no physical health difficulties or neurological symptoms relevant to dysphagia/communication? | Yes  No | If yes – A referral to our service is not considered appropriate.  Please consider a referral to mental health services. |
| Does the patient have a diagnosis of Motor Neurone Disease (MND) and under the Leeds MND team? | Yes  No | If yes - Please refer to the SLT Specialist for MND at Leeds General Infirmary via [leedsth-tr.sltreferrals@nhs.net](mailto:leedsth-tr.sltreferrals@nhs.net) |
| Is the reason for the referral due to reduced oral intake only (with no swallowing difficulties identified)? | Yes  No | If yes - please consider a referral to Dietetics. |
| Are the difficulties related to swallowing tablets/medication only? | Yes  No | If yes - liaise with GP/Pharmacy to see if medication can be taken in an alternative form. |
| Is the reason for the referral for saliva management only?  E.g. increased drooling | Yes  No | If yes – please liaise with GP for saliva management treatment options. |

**Referrer details:**

|  |  |
| --- | --- |
| Referrer name: |  |
| Job title: |  |
| Address: |  |
| Contact number: |  |
| Email address: |  |
| Date of referral: |  |

**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.

**Please return this completed form by email to** [**lcht.speechandswallowing@nhs.net**](mailto:lcht.speechandswallowing@nhs.net)

Speech and Swallowing Team

Woodhouse Health Centre, Cambridge Road, Woodhouse LS6 2SF

Tel: 0113 843 3126

**Patient details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title** |  | **Surname** |  |
| **Forename(s)** |  | **Date of birth** |  |
| **Contact number** |  | **NHS number** |  |
| **Address** |  | | |
| **Main contact (if not the patient)** | Name: | Relationship to the patient: | Contact details: |
| **Communication** | Main spoken language:  Main written language : | Interpreter required:  Yes  No  Need for information to be provided in any other format ( eg large print) please specify: | |

**Lone worker risk:**

Home visits are carried out by lone therapists. Are you aware of any risks presented by the patients’ or relatives’ behaviour or within/in the vicinity of the patient’s home?

Yes  No

*If your answer is yes, please provide further details here:*

|  |  |
| --- | --- |
| **Primary medical diagnosis and relevant medical history**  (Please note that patient summaries are **NOT** appropriate) |  |

|  |  |  |
| --- | --- | --- |
| **Is the person on a palliative or fast track pathway?** | Yes  No | *If yes, please specify current status e.g. GSF framework status (red, yellow, green, blue):* |
| **What is the person’s Rockwood Frailty Score?** |  | |

**Consent:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Has the person given their informed consent to this referral?** | Yes  No | If you have answered no, is it because the patient lacks capacity to give their informed consent at this time? Yes  No | Who has been consulted when making this referral in the person’s best interests? |
| **Electronic patient record (share out)** | I consent to my speech and language therapy service electronic patient record being seen by other health services who are providing care to me: Yes  No | | |
| **Electronic patient record (share in)** | I consent to my speech and language therapy service seeing the electronic patient records for me of other health services providing care to me: Yes  No | | |

**Referral details:**

|  |  |  |
| --- | --- | --- |
| **Reason for referral** | Swallowing  Communication  Both | |
| **Has the person been seen by SLT before?** | Yes  No | If you have answered yes, please provide details (location, outcome of input, any change since previous input etc): |
| **Is this a new episode of difficulty?** | Yes  No | If your answer is no, has there been a recent change?Yes  No |

**Swallowing:**

**PLEASE ONLY COMPLETE THIS SECTION IF THE REASON FOR YOUR REFERRAL IS SWALLOWING.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **What type of food/drink is the person having at present?** | | | | | | |
| **FOOD (IDDSI descriptors)** | 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 |
| **DRINKS (IDDSI descriptors)** | Level 0 Thin | Level 1 Slightly thick | Level 2 Mildly thick | Level 3 Moderately thick | Level 4 Extremely thick |  |

|  |  |
| --- | --- |
| **Changes/new concerns relating to eating/drinking/swallowing:**  ***Please tick all that apply.*** | |
| Coughing when eating  More than once a day  More than once per week  Other | Coughing when drinking  More than once a day  More than once per week  Other |
| Choking incidents requiring intervention e.g. back slaps, abdominal thrusts, ambulance attendance?  *If ticked, please specify:* | Chest infections  *If ticked, how many within a 6 month period?* |
| Mouth-holding | Difficulties chewing |
| Sticking sensation in the throat when eating and/or drinking | A gurgly, wet-sounding voice when eating/drinking |
| Significant weight loss relating to the person’s swallowing difficulties  *If ticked, please specify:* | Food or drink residue left in the mouth |
| Other  *Please specify:* | |

|  |  |
| --- | --- |
| **Is there a high level of patient and/or relative/carer distress?** | Yes  No  **If you have answered yes, please provide further details:** |

**Do you have any other relevant information?** E.g. level of assistance required, frequency of difficulties etc.

**Communication:**

**PLEASE ONLY COMPLETE THIS SECTION IF THE REASON FOR YOUR REFERRAL IS COMMUNICATION.**

|  |  |
| --- | --- |
| **Changes/new concerns relating to communication:**  ***Please tick all that apply.*** | |
| Difficulties understanding language | Difficulties expressing information |
| Acquired reading difficulties (not including developmental difficulties) | Acquired writing difficulties (not including developmental difficulties) |
| Unclear speech | Low volume/quiet voice (related to a neurological condition) |
| Other  *Please specify:* | |

|  |  |
| --- | --- |
| **Is the person’s communication difficulty presenting a barrier to them fulfilling a significant life role e.g. employment, study, parenting, caring, living independently?** | Yes  No |
| **Is there a high level of patient and/or relative/carer distress related to the communication impairment?** | Yes  No  *If you have answered yes, please provide further details:* |

**Do you have any other relevant information?** E.g. referrer concerns, the impact the communication difficulties are having on the person etc.

**Other relevant information:**

|  |  |
| --- | --- |
| Is the person able to attend a clinic appointment? | Yes  No  *If you have answered no, please give your reason here:* |
| **Can the person access input from our service via telehealth?**  *Please note: The person would need a small device e.g. smartphone, iPad, laptop etc with access to WiFi.* | Yes  No |

**Thank you for completing our referral form. Please return this completed form to** [**lcht.speechandswallowing@nhs.net**](mailto:lcht.speechandswallowing@nhs.net)**.**

*Note: Any incomplete referrals will not be accepted and will be sent back to the referrer for completion.*