**ADULT Community Speech and Language Therapy Referral Form**

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| **Southampton City (SO14-SO19) acceptance criteria:** **patients over 16 years with an acquired swallow and/or communication disorder**  **West Hampshire (SO30, SO40-SO45, SO51-SO52, BH24-BH25) acceptance criteria:** **patients aged 16-\*65 years with an acquired neurological swallow and/or communication disorder excluding idiopathic Parkinson’s disease, stroke, head injury and dementia.**  **\* Unless diagnosis of MND where all ages accepted** | | |
| **Exclusions**   * End of life feeding where there is no clinical indication for SLT intervention/ SLT intervention will not add value/ patient in final days of life/not eating and drinking as natural part of dying process | | |
| * Patient unable to participate in SLT intervention due to reduced levels of alertness -> re-refer if patient improves | | |
| * Patients who have mental capacity to make informed choices about their health and have declined SLT input | | |
| * Patient is eating and drinking at risk, this has been documented and   there have been no changes since documentation. |  | Continue swallow management as per  care plan |
| * If a patient has difficulty chewing food due to poor dentition but no   other swallowing difficulties. |  | Liaise with Dentist |
| * If a patient has difficulty swallowing tablets but in the absence of any   other swallowing difficulty. |  | Request GP/ Pharmacist to review medication |
| * Patients with weight loss but in the absence of a swallowing problem. |  | Liaise with GP or Dietetics |
| * Patients with vomiting or gastro-oesophageal problems but in the   absence of an identified oro-pharyngeal swallowing difficulty. |  | Liaise with GP or Gastroenterology |
| * For patients who already have a SLT care plan and are currently   stable with no new SLT goals identified. |  |  |
| * For patients whose primary swallowing or communication difficulties   relates to head and neck surgery, laryngectomy or tracheostomy  (Referrals will be accepted for those patients with tracheostomy and  communication difficulties). |  | Liaise with SLT team at University Hospitals Southampton (UHS) |
| * Patients with communication impairment related to a mental health   diagnosis. |  | Liaise with mental health services |
| * For patients with voice problems in absence of a neurological   disorder. |  | Liaise with SLT team at University Hospital Southampton (UHS) |
| * For patients with a stammer which has not been acquired due to   neurological disorder. |  | Patient to consider private options for SLT input E.G <https://asltip.com> (Association of SLTs in Private Practice) |
| * Patients with developmental language or speech sound difficulties. |  | Patient to consider private options for SLT input E.G <https://asltip.com> (Association of SLTs in Private Practice) |

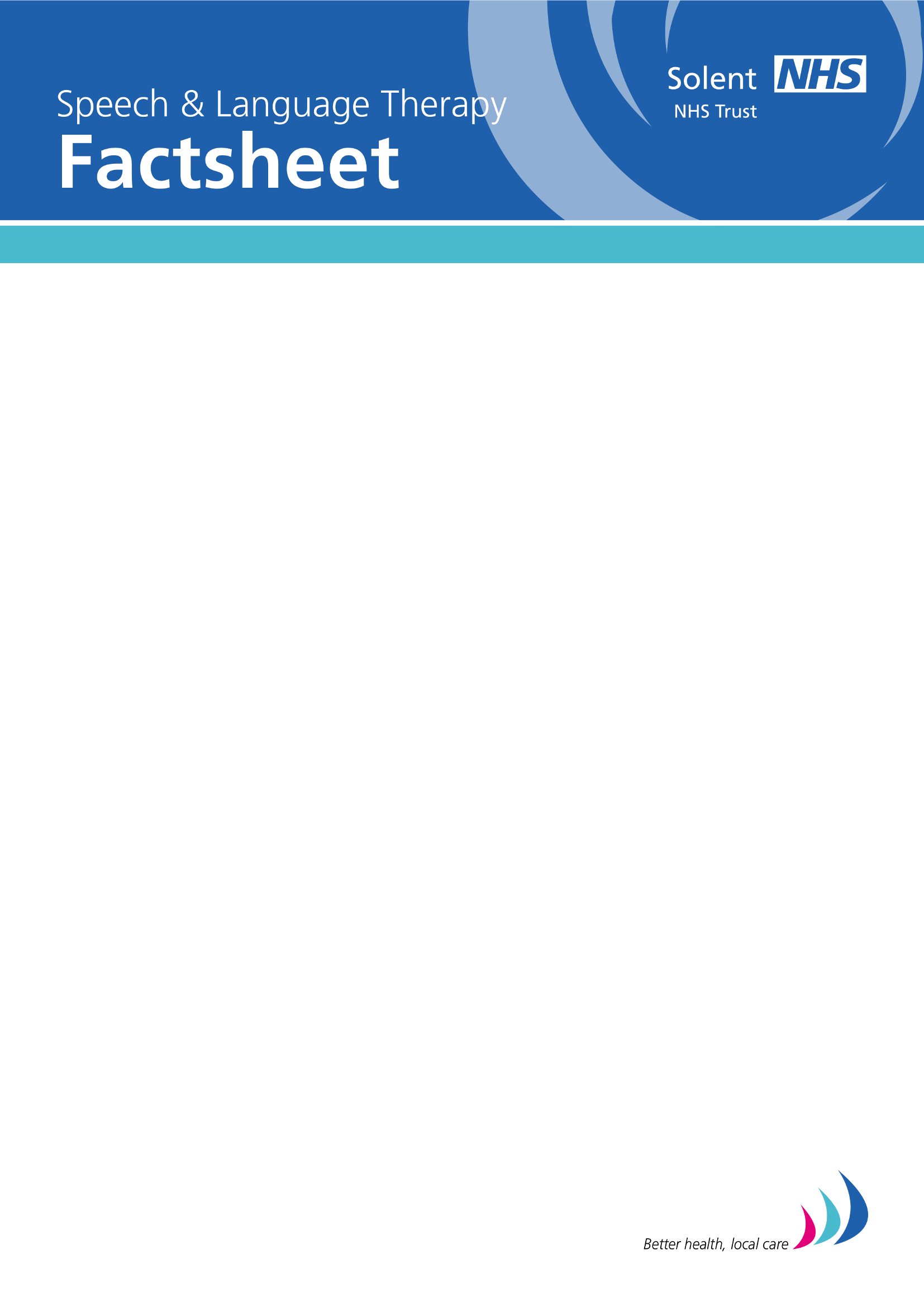
**Adult Community Speech and Language Therapy (Southampton) Referral Form**

Please use this form to refer people with swallowing and/or communication difficulties for Outpatient or Community services. To help the team to triage and prioritise the referral appropriately, please complete this form in its entirety.

**NOTE: referrals will be declined if -**

* Referral form is incomplete
* Referrals for Nursing Home/Care Home residents with swallowing difficulties do not include a **dysphagia checklist**
* End of life where there is no clinical indication for SLT intervention/ SLT intervention will not add value/ patient in final days of life/not eating and drinking as natural part of dying process

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| **INFORMATION ABOUT THE PERSON BEING REFERRED** | |
| **Name:** | **Telephone Number:** |
| **NHS Number:** | **NOK (and relationship):** |
| **DOB:** | **NOK Contact number:** |
| **Address:** | **Who should we contact to arrange an appointment?**  Patient  NOK  Other (*please state)* |
| **GP Practice (and partnership):** | **Home situation:**  **Does patient live alone?** Yes  No  **Does patient have carers?** Yes  No |
| **Has the patient consented to referral?**  Yes  No  Best interest | **Are there safeguarding concerns?** Yes  No  **If so, please provide further information below.** |
| **Does the patient require a home visit?**  Yes  No  **If so, why?**  **Are there any lone working risks?**  Yes  No  **If so, please provide further information below.** | **Do you anticipate that SLT intervention is required to support with mental capacity related to swallowing or communication?**  Yes  No  Don’t Know  Please comment if Yes: |
| **CLINICAL INFORMATION** | |
| **Reason for referral**  **Swallowing**  *(see inclusion/exclusion criteria attached)*  **Communication**  *(see inclusion/exclusion criteria attached)* | **Brief history, duration of present condition and any identified goals:** |
| **Past medical history** *(including any sensory impairment e.g. hearing/visual)* | **Does this person have any of the following?**  Significant weight loss / Malnutrition  Occasional coughing with oral intake  Persistent coughing with oral intake  UTI / Dehydration  Recent chest infection  Recurrent chest infections  Choking Episodes (**severe** difficulty in breathing  because of food/drink **obstructing** airway)  Other (Please specify  …………………………………  None of the above |
| **EATING & DRINKING –** only complete this section if referring for difficulties with eating and drinking | **COMMUNICATION -** only complete this section if referring for difficulties with communication |
| **If referring for swallowing difficulties:**  **What FOOD is the person currently having?**  Regular food textures  Modified food textures  If so, what texture (e.g. pureed/blended, mashed, soft/lumpy)?  **What DRINKS is the person currently having?**  Thin  Naturally thickened drinks (E.G smoothies, milkshakes)  Thickened drinks using prescribed thickener  **Are they Nil by mouth?**  Yes  No    **Are they having alternative feeding?**  Yes  No  **Nasogastric tube**  **Gastrostomy** | **Can they call for help if required?**  Yes  No  **Are these difficulties impacting on their ability to return to work in the next 3 months?**  Yes  No  If yes, what is return to work date?  **Any other information or risks that would be helpful for us to be aware of?** |
| **REFERRER DETAILS** | |
| **Name & Designation:** | **Referrer workplace address:** |
| **Contact telephone Number:** | **Email address:** |
| **Date of referral:** | **Signed by Referrer:** |
| **Please send referral as below:**  **If using Systm1:** Send via electronic referral, selecting the following task recipient: *Speech & Language (Adult) Referral* ***(for Outpatients)***  **If not using Systm1:** Email to[adultcommunitysalt@solent.nhs.uk](mailto:adultcommunitysalt@solent.nhs.uk) | Adult Community Speech & Language Therapy  Western Community Hospital  William Macleod Way  Southampton  SO16 4XE  Tel: 0300 123 3948  Email: [[adultcommunitysalt@solent.nhs.uk](mailto:adultcommunitysalt@solent.nhs.uk)](mailto:CNRT1@Solent.nhs.uk) |





**Inappropriate Referral Signposting Document**

Our service covers adults (aged 16+) with a Southampton City GP with an acquired or progressive neurological diagnosis. We cover a small proportion of patients with a West Hants GP with a progressive neurological diagnosis, who are under 65 and require a home visit.\*

*\*please note we see patients with a diagnosis of Motor Neurone Disease regardless of their age and home visit requirements.*

**Our exclusion criteria include (*but is not limited to*)**

* Voice difficulties
* Hearing impairment adults with learning difficulties
* Adults with learning difficulties (ALD)
* Dysfluency / Stammering
* Developmental disorders and mental health disorders.
* End of Life (EoL) patients where there is no clinical indication for SLT intervention e.g. intervention will not add value, in final days of life or not eating and drinking as natural part of dying process.

**Other services that you may wish to consider referring your patient on to are:**

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| **Client Group** | **Appropriate service for referral** |
| ***For mental health SLT input:*** | Speech & Language Therapy – OMPH, Southern Health  Tom Rudd Unit  Moorgreen Hospital  Botley Road  Southampton  SO30 3JB  02380 475336 |
| ***For patients with a neurological diagnosis,*** *living in West Hants.*   * ***Those who are over 65*** *(Excluding patients with a diagnosis of MND)* * ***Patients aged 16+ who are able to attend an outpatient appointment*** *(Excluding patients with a diagnosis of MND)* | Hobbs Rehabilitation  Speech & Language Therapy  Unit 1  Bridgets Farm offices  Bridgets Lane  Winchester  SO21 1AR  01962 779796  Email:  [hiowicb-his.hobbsrehabilitation@nhs.net](mailto:hiowicb-his.hobbsrehabilitation@nhs.net) |
| ***For SLT input with a diagnosis of Adult learning Disability (ALD)*** | Adult Community Learning Disability Team  Speech & Language Therapy  Thomas Lewis House  236 Empress Road  Southampton  SO14 OJY  02382 310 300  Email - scldt@southernhealth.nhs.uk |
| ***For patients with a voice difficulty requiring SLT input.*** | Speech & Language Therapy - Voice Therapy  Department of Speech and Language Therapy and Dietetics  Level A, Mailpoint ODT  Royal South Hants Hospital  Brinton’s Terrace  Southampton  SO14 0YG  Telephone: 023 8120 2954 |
| ***For patients with a Stammer*** | Private Speech & Language Therapy  Association of Speech and Language Therapists in Independent Practice  <https://asltip.com> |
| ***Patients who are End of Life*** | See attached for further information, if appropriate |

Please do not hesitate to contact the Solent Speech and Language Therapy service should you have any queries.

Telephone number - 0300 123 3948  
Western Community Hospital, William McLeod Way, SO16 4XE

