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| **Aberdeen City Health and**  Social Care Partnership  **Speech & Language Therapy**  Community Adult Service Referral Form (Revised May 2021) | **Aberdeen Health Village**  **50 Frederick Street**  **Aberdeen**  **AB24 5HY**  Tel: 01224 655628 or **Duty SLT Advice Line: 01224 558 377** | NHS_Grampian_faxlogo |

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| **Name of Person being referred:** | | | | | **Date of Birth:** | | | | | |  | **M** | **F** |
| **CHI:** | | | | | |  |
| **Address** | | | | | **Registered GP & GP Practice** | | | | | | | | |
| **Telephone Number** | | | | | **GP Phone Number** | | | | | | | | |
| **Does person have access to computer or Smartphone to allow a video call appointment?**  Yes  No | | | | | **If person being referred is willing to consider a video call appointment, please give their e-mail address:** | | | | | | | | |
| **Medical History**  *(printout from GP is helpful)* | | | | | **Medication**  *(attach separate sheet if easier)*  **Are there any current issues in swallowing medication?** Yes  No  **If Yes, give details in Section A.** | | | | | | | | |
| **Reason for Referral:**  (Place a cross beside one or both) | | | **Swallowing Assessment**  (Please complete **Sections A, B & D**)  **Communication Assessment**  (Please complete **Sections C & D**)  If referral is for both Swallowing and Communication Assessment, please complete all sections. | | | | | | | | | | |
| **Section A - Referral for Swallowing Assessment**  **All referrals for swallow assessment must be discussed with the person’s GP**  **Please place a cross in this box to confirm GP is aware** | | | | | | | | | | | | | |
| **Describe current difficulties with eating, drinking and swallowing (including any problems when taking medication), when the difficulties started and the reason for referring at this time:** | | | | | | | | | | | | | |
| **Section B - Referral for Swallowing Assessment (continued)** | | | | | | | | | | | | | |
| **Current Texture of Foods and Drinks (International Dysphagia Diet Standardisation Initiative (IDDSI) - Level Descriptors)**  Indicate the appropriate Level X X | | | | | | | | | | | | | |
| **FOODS** | 7 | Regular (Normal) | |  | | **DRINKS** | | | 0 | Thin (Normal) | | |  |
| 6 | Soft & Bite-Sized | |  | | 1 | Slightly Thick | | |  |
| 5 | Minced & Moist | |  | | 2 | Mildly Thick | | |  |
| 4 | Pureed | |  | | 3 | Moderately Thick | | |  |
| 3 | Liquidised | |  | | 4 | Extremely Thick | | |  |
| **Please use the box below if you wish to describe the current foods and drinks taken in more detail.** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Describe any actions already taken to support these difficulties with eating, drinking and swallowing (including when taking medication) and their effectiveness:** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Nutritional Status** | | | | | | | | **Chest Status** | | | | | |
| *(including current weight; MUST score; any weight loss over the last 6 months)* | | | | | | | |  | | | | | |
| **Level of assistance required with meals** | | | | | | | | **Feeding Aids** | | | | | |
|  | | | | | | | |  | | | | | |
| **Oral Health** | | | | | | | | **Dentition** | | | | | |
|  | | | | | | | |  | | | | | |
| **Any difficulties with following instructions or understanding** | | | | | | | | **Any previous SLT Input / Videofluoroscopy** | | | | | |
|  | | | | | | | |  | | | | | |
| **Section C - Referral for Communication Assessment** | | | | | | | | | | | | | |
| **Describe current difficulties with communication and the reason for referring at this time:** | | | | | | | | | | | | | |
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| **Describe any actions already taken to support these communication difficulties and their effectiveness:** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **Hearing / Vision** | | | | | | | | **Are there any Communication Aids in place? (Life story or communication book, communication device, etc.)** | | | | | |
|  | | | | | | | |  | | | | | |
| **Section D – Information about Referrer** | | | | | | | | | | | | | |
| **Your Signature** | | | | | | |  | | | | | | |
| **Your Name** | | | | | | |  | | | | | | |
| **Your Designation** *(Referral form should only be completed by Senior Staff)* | | | | | | |  | | | | | | |
| **Your Contact Telephone Number** | | | | | | |  | | | | | | |
| **Date of Referral** | | | | | | |  | | | | | | |
| * ***Please make sure that you have completed all the relevant sections and that all 3 pages of the referral are sent to our Service.*** * ***Please post the referral to the above address or e-mail to gram.citysltadults@nhs.scot*** | | | | | | | | | | | | | |