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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:** |
|  |
| **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***
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