

**SLT Adults East SPA/S1 Referral Form V7 October 2019  
Speech and Language Client Referral Form**

**Portsmouth City, Fareham and Gosport and SE Hants (NB. SLT community East)**

**Please register on System 1 to SLT Adults SPA caseload and SPA waiting list.**

Please confirm client details on system 1 are correct.

All questions should be asked. Referrals are only accepted if mandatory (grey) fields are completed.

**Please phone this referral to SPA 0300 300 2011 or email to [SNHS.SPA@NHS.net](mailto:SNHS.SPA@NHS.net)**

<b>NHS Number:</b>	
<b>Client Name:</b>	
<b>DOB:</b>	
<b>Client Address (confirmed or updated):</b>	
<b>Client Telephone (confirmed or updated):</b>	
<b>Client's current location:</b>	
<b>Access code/keysafe number:</b>	
<b>Referrers Name:</b>	
<b>Referrers Address:</b>	
<b>Referrers Tel No:</b>	
<b>Referrers <u>secure</u> email address:</b>	
<b>Referrers Job title or Relationship to client:</b>	
<b>***If caller is a <u>Parkinson's or MS Nurse</u> or SLT from Community Stroke Rehab Team (CSRT) please answer questions 1 &amp; 9-13 <u>ONLY</u>***</b>	
<b>CALL HANDLER:</b>	
<b>DATE:</b>	

**Please note incomplete referrals will not be accepted by SLT as all the information is required to be able to triage the referral accurately.**

<b>Has the patient consented to referral?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If the answer is no, a reason is required</b>	
<b>1.Reason for referral?</b> <input type="checkbox"/> <b>Communication Difficulty (Explain)</b> <input type="checkbox"/> <b>Swallowing Difficulty (see questions below)</b>	
<b>2. Brief history and duration of the difficulty</b>	
<b>3. Please describe the client's relevant medical history. This is essential information for SLT to assist with triage and priority rating</b>	
<b>4. Swallowing Status:-</b> <b>This information is needed for all swallow referrals to ensure accurate triage. Give the food and drink options below if necessary</b>	

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<p>What <b>FOOD</b> are they currently taking?</p> <input type="checkbox"/> Normal Diet <input type="checkbox"/> Easy to Chew Level 7 <input type="checkbox"/> Soft and Bite sized Level 6 ( <i>Previously known as Texture E fork mashable diet</i> ) <input type="checkbox"/> Minced and Moist Level 5 ( <i>Previously known as Texture D pre- mashed diet</i> ) <input type="checkbox"/> Thick pureed Level 4 <input type="checkbox"/> Thin puree – liquidised Level 3 <input type="checkbox"/> Nil By Mouth <input type="checkbox"/> Alternative Feeding (PEG) <p>What <b>DRINKS</b> are they currently taking?</p> <input type="checkbox"/> Thin <input type="checkbox"/> Naturally / slightly thick Level 1 <input type="checkbox"/> Mildly thick Level 2 ( <i>Previously known as Stage 1 syrup consistency</i> ) <input type="checkbox"/> Moderately thick Level 3 ( <i>Previously known as Stage 2 – custard consistency</i> ) <input type="checkbox"/> Extremely thick Level 4 ( <i>Previously known as Stage 3 pudding consistency</i> )	
<p><b>5. Do they have difficulty swallowing medication?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p><b>6. Is the person coughing when eating?</b></p> <input type="checkbox"/> Yes - <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> No <p><b>Is the person coughing when drinking?</b></p> <input type="checkbox"/> Yes - <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> No	
<p><b>7. Has this person choked (airway fully obstructed)</b></p> <input type="checkbox"/> Yes – What happened? What food were they eating? What help did they need? <input type="checkbox"/> No	
<p><b>8. Has the patient had any confirmed unexplained chest infections in the last 3 months (requiring medication)?</b></p> <p>If yes, how many? _____</p>	
<p><b>9. Does client live alone?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p><b>10. Is this person capable of attending an outpatient appointment?</b></p>	

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<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>11. Does the patient have a package of care or any community service in place?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>12. Risks or hazards to visitors? (explain)</b>	
<b>13. Family / Next of Kin Details</b> This question is important as the person being referred may not be able to answer the phone or respond to a letter due to their difficulties	

**Referrals from Parkinson’s Nurse or CSRT:** A separate more detailed report will be sent to the S&LT team by the referrer

**If Using SystemOne:** Please send this form via electronic referral selecting the following task recipient  
1 SaLT eReferral

**IMPORTANT NOTICE**

**Food and fluid descriptors have changed**

The **International Dysphagia Diet Standardisation Initiative (IDDSI)** is a global standard to describe texture modified foods and thickened drinks for individuals with swallowing difficulties of all ages, in all care settings. This change came into effect on 1<sup>st</sup> April 2019.

The IDDSI framework consists of a continuum of 8 levels (0-7). Levels are identified by labels, numbers and colour codes to improve safety and identification. The standardised descriptors allow for consistent production and testing of thickened drinks and texture modified foods.



Copyright: The International Dysphagia Diet Standardisation Initiative 2016  
@ <https://idlsi.org/framework/>

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