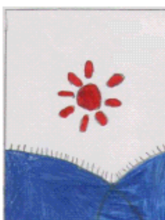

Community Services NHS
Part of Heart of England
NHS Foundation Trust

SPECIALIST ASSESSMENT SERVICE
REFERRALS FOR DYSPHAGIA ONLY

CHILD AND PARENTS/CARERS DETAILS:

Child/Young Person's Name:	**Date of Birth:**
Child's Address: **Postcode:**	
Male or Female *(please circle)*	Is this child/young person looked after by the Local Authority? **YES / NO** *(please circle)*
NHS No:	
Name of Child/Young Person's GP:	
Telephone Number of GP :	
Address of GP Practice: **Postcode:**	

Please tick as appropriate		Asian/Asian British – Pakistani	
White British		Asian/Asian British – Bangladeshi	
White Irish		Any Other Asian Background	
Any Other White Background		Black/Black British Caribbean	
Mixed White & Black Caribbean		Black/Black British African	
Mixed White & Black African		Any Other Black Background	
Mixed White & Asian		Other Ethnic Groups – Chinese	
Any Other Mixed Background		Any Other Ethnic Group	
Asian/Asian British – Indian		Not Stated	

Please give full names and addresses (if different) of each parent/carer responsible for this child/young person where applicable **(please indicate who has designated parental responsibility)**

Name:	**Name:**
Mother Father Carer (please circle)	**Mother Father Carer (please circle)**
Address:	**Address:**
Postcode:	**Postcode:**
Contact Telephone Number: *Can a message be left on these numbers?* Yes/No Home: Mobile:	**Contact Telephone Number** *Can a message be left on these numbers? Yes/No* Home: Mobile

REFERRER DETAILS Please tell us who is completing this referral.

Name:	Role: (Parent/professional role)
Address:	Contact Number:

Who is currently involved with the child/young person? E.g. Paediatrician, Health Visitor, Speech and Language Therapist, Social Care. If child/young person is currently supported by Social Care please put full details below and explain why they were involved.

Name	Title/Profession	Contact Information

Please complete the referral information as fully as possible to help the triage process:

Childs medical diagnosis and medical history	
Description of current eating and drinking difficulties (why you are referring)	
Details of Childs weight loss or gain	
Current Medication	
Current eating Describe consistency, preferred foods, estimated quantity and time needed to complete main meal and any reported difficulties	
Current Drinking Describe utensils used, preferred drinks and any reported difficulties	
Please detail Parental / Carer concerns	

Has the Child had SLT input for eating and drinking difficulties previously? Please give details	
Has the child had any Videofluoroscopy Studies carried out? Please give details	

Is there history of: (please tick and give details)

Chest infections		
Choking		
Frequent coughing when eating or drinking -		
Discomfort following a meal		
Regurgitation/reflux		
Constipation		
Urinary infection		
Gagging		
Vomiting		
Food refusal		
General sensory defensiveness		
ENT problems		
Any other comments:		

REFERRAL RATING*: (For office use – please do not complete)*
Priority 1 – child will be seen within 2 working days
Priority 2 – child will be seen within 10 working days
Priority 3 – therapist will review in person or by telephone within 13 weeks