**Children’s Speech and Language Therapy Service Referral Form**

**Eating and Drinking (Dysphagia)**

**Telephone:** 0300 1310 111 **Email:** [provide.ccc@nhs.net](mailto:provide.ccc@nhs.net)

Note: Provide services work to NHS Connecting for Health policies and can only send responses including patient identifiable details (PID) to email addresses that are approved by them. If you are not using an approved email address this may limit the response we can make by email.

Please note we are **not** commissioned to assess and treat eating and drinking difficulties that are related to the following:

* Avoidant Restricted Food Intake Disorder (ARFID)
* Sensory difficulties without underlying medical cause
* Eating and drinking difficulties associated with autism without underlying oro-motor difficulties
* Eating and drinking difficulties associated with mental health conditions

Our service is open to children 1-11 years old within a mainstream setting, and up to 19 years in a special school setting.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of referral: | | NHS number: | | | |
| **Patient Details** | | | | | |
| Forename: | | | | Surname: | |
| Address and postcode: | | | | | |
| Date of birth: | | | | Gender: | |
| Home telephone: | | | | Mobile telephone: | |
| Allergies: | | | | Ethnicity: | |
| **GP Details** | | | | |
| Registered GP: | | | Telephone: | |
| GP Practice or F Code: | | | | |
|  | | | | |
| **School Details** | | | | |
| Pre-school/nursery address: | Telephone number: | | | |
| Name of leader/teacher: | Name of SENCO: | | | |

|  |  |
| --- | --- |
| **Family information** | |
| Name of parents/carers: |  |
| Names of other adults living at the child’s address: |  |
| Names and DOB of siblings: |  |
| Other: |  |

|  |
| --- |
| **Languages spoken at home/ Interpreter needed:** (please complete) |
|  |

|  |  |
| --- | --- |
| **Previous contact with service** | |
| **Has this child had contact with speech and language therapy for eating and drinking support before?** | **IF ‘YES’** - IF THE CHILD WAS DISCHARGED WITHIN LAST 12 MONTHS (please outline what has changed since the child was discharged). |

|  |
| --- |
| **Birth History:** |
| *To include: was the baby full term, born prematurely, need any specialist medical intervention such as ventilation, tube feeding etc.* |

|  |
| --- |
| **Early Feeding Journey:** |
| *Please include how baby fed at birth, any difficulties, progression weaning etc.* |

|  |
| --- |
| **Medical Diagnosis:** |
| *Please include any current medications associated with medical conditions.* |

|  |
| --- |
| **Current Method of Nutrition:** |
| *Orally fed, Nasogastric tube, gastrostomy, combination* |

|  |
| --- |
| **Reason for Referral:** |
|  |
| **Does the child present with a history of:**  Recurrent chest infections: Yes / No  Frequent coughing when eating/drinking: Yes / No  Changes in breathing when eating/drinking: Yes / No  Gagging when eating/drinking: Yes / No  Vomiting when eating/drinking: Yes / No  Gastro-oesophageal reflux: Yes / No  Concerns over weight gain: Yes / No  If yes to any of the above please provide details: |

|  |  |  |
| --- | --- | --- |
| **Details of other Professionals involved:** | |  |
| Local Paediatrician: |  | |
| Consultants: (including respiratory, neurology, Ear, Nose and Throat, cardiology, gastroenterology etc.) |  | |
| Dietitian: |  | |
| Physiotherapist: |  | |
| Occupational Therapist: |  | |
| Social Worker: |  | |
| Health Visitor: |  | |
| Other: |  | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Parents/carers | | | | | Referrer | | | | |
| **Level of concern** | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Scale 1-5 (1 = low, 5 = high)  Please tick |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| **Other information** |
| Child protection status: |

|  |  |  |
| --- | --- | --- |
| **Referrer details** (complete if not patient’s GP) |  | Tick if patient’s GP |
| Name: | Job role: | |
| Organisation\service: | Telephone number: | |
| Sender address: | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Consent** | | | | | | | |
| Please give date of consent to this referral: | | |  | | | | |
| Name of person giving consent: | | |  | | | | |
| Signature of person giving consent: | | |  | | | | |
| Role: (please tick **✓**) |  | Parent | |  | Carer |  | Social worker |

Please ensure that this form is completed fully preferably with parent/carer.

Incomplete forms will not be accepted.

**Please return to:** Provide, Care Co-ordination Centre, SLT Service, Colchester Business Park, 900 The Crescent, Colchester, CO4 9YQ **or** [provide.cccpaediatrics@nhs.net](mailto:provide.cccpaediatrics@nhs.net)