Specialist Children’s Services

**SPEECH AND LANGUAGE THERAPY (SaLT)**

**DYSPHAGIA (Feeding and Swallowing) REFERRAL FORM**

**FOR CHILDREN/YOUNG PEOPLE REGISTERED WITH A**

**HAMBLETON & RICHMONDSHIRE OR HARROGATE DISTRICT GP**

**Please note the referral may not be accepted if there is insufficient information.**

**Please call 01423 542490/553122 to request alternative/accessible formats of this form.**

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| --- | --- | --- | --- | --- |
| **Has the child/young person had any input from Speech and Language Therapy previously?**  Yes  No  Don’t know | | | | |
| Child’s/young person’s name:  Address:  Parent/carer telephone no:  Email address (and consent to contact via email): | | | Date of birth:  Gender:  NHS No (if known): | |
| School / Nursery:  School/Nursery contact telephone number and email:  Current year group: | | | | |
| Name of Parent/Carer(s):  Relationship to child/young person: Who has parental responsibility?  Is the child/young person fostered or adopted? (optional) Yes  No  (please specify)  Who lives at home with the child/young person?  Is there any family history of speech, language, or communication difficulties? | | | | |
| Are there any safeguarding concerns?  Is the child/young person subject to a Looked After Child review? | | Yes  No  Yes  No | | |
| If yes, please give further details (include social worker/family support worker details): | | | | |
| GP details:  Other professionals involved (e.g. Audiology, SEND Hubs, Paediatrician, Educational Psychologist, Physiotherapy, Occupational Therapy, Autism Assessment Team):  *Please attach relevant reports if available* | | | | |
| **Background information**  Was the child/young person born full-term (on/near their due date) and did they require any special care when first born?    Does the child/young person have any known medical conditions or diagnoses? (e.g. autism, cerebral palsy, cleft palate, developmental delay, Down syndrome)  Does the child/young person take any medications?    Did you have concerns about the child/young person’s early development? (e.g. walking, first words, toilet training) Please specify.  Did the child/young person have any difficulties with feeding or weaning? | | | | |
| **What are your current concerns about feeding and swallowing?**    **Level of concern:**  1 = not at all concerned, 10 = very concerned   |  |  | | --- | --- | | **Family:** | 1          2          3          4          5          6          7          8          9          10 | | **Referrer:** | 1          2          3          4          5          6          7          8          9          10 | | **Child/Young Person:** | 1          2          3          4          5          6          7          8          9          10  (if not applicable leave blank) | | | | | |
| **Languages spoken in the home:**  Length of time exposed to English:  Is an interpreter or signer required? YES  NO  Can parents/carers understand English written information? YES  NO | | | | |
| **What do you want help with from the SaLT team?**  How are the difficulties affecting the child’s/young person’s everyday life at home and at school? Please provide specific examples.    What strategies have already been tried at home or at school to help the child/young person and what impact have they had? | | | | |
| Parental consent  The SaLT team work with other healthcare, education, and social care professionals to support children, young people and families. We often share health information and reports with these professionals, with your consent. If you do not wish for this information to be shared, please inform your child’s/young person’s speech and language therapist.  Please sign below to confirm that you have read and understood the above information, and to consent to a referral to the speech and language therapy team.  Signed (parent/carer):  Date: | | | | |
| Appointments  We currently offer appointments at the following clinics. Please tick the clinic(s) you would be able to attend:  Virtual (online via Teams video link)  Harrogate  Northallerton/Bedale  Catterick  Soonest appointment at any clinic  Please note you may have a longer wait for an appointment if you wish to attend a specific clinic. | | | | |
| Other relevant information: | | | | |
| Signed Referrer: | Designation/Role: | | |
| PRINT Name: | Date: | | |
| Address: | Telephone Number: | | |

**Please email completed referral forms to:** [**hdft.scsadmin@nhs.net**](mailto:hdft.scsadmin@nhs.net)

**Additional information for Feeding and Swallowing referral**

|  |  |
| --- | --- |
| Current height: | Current weight: |

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| **Please indicate the swallowing or feeding concerns: *(Please complete with parents/guardians)***  **Using the table below please indicate if any of these are true for the infant/child by ticking the relevant boxes:**   |  |  |  |  | | --- | --- | --- | --- | | Frequently coughs / chokes with food and / or drink |  | Verbally reports difficulty swallowing or “things getting stuck’’ |  | | Has a history of frequent chest infections |  | Parental or professional concern about the mechanics of eating or drinking |  | | Shows signs of stress when eating or drinking, e.g. sweating, skin pallor change, eye tearing etc. |  | Struggling with age appropriate lumpy or mashed food over 9 months of age **with** vomiting or gagging in evidence |  | | Has increased wheezing when breathing, specifically associated with eating / drinking |  | Has significant food aversion that is preventing development of age appropriate oro-motor skills |  | | Has apnoea or cyanotic attacks associated with eating / drinking |  | Has nasal regurgitation of food when eating / drinking |  | | Has a ‘watery’ voice during or after meals |  | Has significant food/drink refusal in association **with** medical intervention resulting in restricted diet e.g. GOR |  | | Has anatomical/structural complications giving concern re swallow safety. |  | Significant parental anxiety about feeding or swallowing skills |  | | Reported deterioration in chewing and swallowing skills |  | Has an identified nutrition concern in addition to any of the above? |  | | Has other muscle/movement problems, e.g. cerebral palsy, muscular dystrophy in association with any of above |  |  |  | | Has difficulty controlling saliva in association with any of the above |  |  |  | | Has struggled to gain weight with any of the above symptoms |  |  |  | | Has required and / or still requires some bolus tube feeds |  |  |  | | Younger premature baby who is not feeding as nurses would expect for his/her gestational age |  |  |  | | Premature baby born with neurological difficulties or a syndrome known to have associated feeding difficulties |  |  |  | | Baby aged 37 weeks and over who is not progressing with bottle feeds |  |  |  | |
| **What specific support would you like from Speech & Language Therapy?**  (a) Assessment / Advice / Intervention as appropriate  (b) Support with differential diagnosis  (c) Other (please explain) |