

CHILDREN'S SPEECH & LANGUAGE THERAPY (SLT) FEEDING/ SWALLOWING (DYSPHAGIA) REFERRAL FORM

CHILD'S NAME: DOB: NHS No:

NAME OF REFERRER: DESIGNATION:

REFERRAL DATE: REFERRER PHONE NO:

REFERRER ADDRESS:

This referral is for assessment of feeding skills only (e.g. biting, chewing swallowing) for children/ young people aged 0-18.

This may include (please tick as appropriate)

- Difficulty chewing
- Coughing on fluids
- Coughing on food
- Prolonged feeding time
- Holding food/ fluid in the mouth
- Choking on food/ fluid
- Recurrent chest infections (3 or more per year)
- Change in breathing sounds during/ after feeding
- Difficulty maintaining clean mouth/ teeth
- Eyes watering/ blinking/ widening during meals
- Poor weight gain/ restricted diet
- Nasal regurgitation
- Gagging on food
- Tires easily during meals

Please contact your health visitor before referring to SLT for support if your concerns are limited to:

- weaning
- weight gain
- limited diet

As a referral to a different service may be required to meet your needs.

NB:

This is not an emergency service. Please speak to your medical team (paediatrician, health visitor, GP) if you have urgent concerns.

PLEASE ENSURE THAT THIS FORM IS FILLED IN FULLY. IT WILL BE RETURNED TO YOU IF ITEMS ARE NOT COMPLETED.
PLEASE CROSS OUT ANYTHING THAT IS NOT APPLICABLE
HEALTH PROFESSIONALS ARE ONLY REQUIRED TO FILL OUT NAME, DOB, NHS NUMBER & EDUCATION SETTING

CHILD'S DETAILS	Sex: M F	PARENT / CARER 1:	PARENT / CARER 2:
Date of Birth:.....	First Name:	First Name:	First Name:
NHS Number (if known):	Surname:	Surname:	Surname:
First Name(s):	Relationship to child:	Relationship to child:	Relationship to child:
Surname:.....	Address (if different from child)	Address (if different from child)	Address (if different from child)
Address:.....	Address (if different from child)	Address (if different from child)	Address (if different from child)
Postcode:.....	Postcode:.....	Postcode:.....	Postcode:.....

GP:	Nursery / School:.....
Address:	Teacher's Name:.....

Language(s) spoken by child (Incl. dialect if relevant):

Language(s) spoken by parent/carer (Incl. dialect if relevant):

Interpreter needed for parent Y N or child? Y N

Length of time the child has been exposed to English?.....

Are there concerns about the child's understanding and use of their home language? If yes, please give details;
.....

Religion:.....

Ethnic Origin (Please tick)

<input type="checkbox"/>	English, Welsh, Scottish, Northern Irish or British
<input type="checkbox"/>	Irish
<input type="checkbox"/>	Gypsy or Irish Traveller
<input type="checkbox"/>	Any other White background
<input type="checkbox"/>	White & Black Caribbean
<input type="checkbox"/>	White & Black African

<input type="checkbox"/>	White & Asian
<input type="checkbox"/>	Any other Mixed or Multiple ethnic background
<input type="checkbox"/>	Indian
<input type="checkbox"/>	Pakistani
<input type="checkbox"/>	Bangladeshi
<input type="checkbox"/>	Chinese

<input type="checkbox"/>	Any other Asian background
<input type="checkbox"/>	African
<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	Any other Black, African or Caribbean background
<input type="checkbox"/>	Arab
<input type="checkbox"/>	Any other ethnic group

Known / referred to other Professionals; (please tick)

- Audiology
- Complex Communication Team
- SEMHL
- Occupational Therapy

- CAMHS
- Educational Psychology
- Physiotherapy
- Medical Consultant / Paediatrician

- SEND Early Years
- Early Support
- Neurodevelopmental Team
- Other (please specify)

Known to Social Care? Y N

Does the family have a CAF? Y N CAF Level

Named Social Worker and Base:

CAF Lead and Base:

Does the child have a EHCP? Y N

Relevant child & family, developmental and medical history (e.g. learning, hearing, visual, mobility, mental health, medical diagnosis, behavioural difficulties):

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.....
.....

PLEASE TELL US ABOUT THE CHILD'S DIFFICULTIES & GIVE EXAMPLES:

Swallowing/feeding concerns	
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What would you like to achieve from this referral?

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.....
.....

Has parent/carer/young person consented to this referral	Yes / No
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<p>You can access our website for general information and waiting times at the following address www.coventrychildrenssl.co.uk</p> <p><u>Please note: referrals will only be accepted if the child or young person is registered with a Coventry GP</u></p>

Please return to:

Children's Speech and Language Therapy Service
Paybody Building
C/O City of Coventry Health Centre
2 Stoney Stanton Road
Coventry
CV1 4FS

Telephone: 024 76961455