NHS
Coventry and
Warwickshire Partnership
NHS Trust

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:.....

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

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: .....
NHS Number (if known):	Surname:	Surname: .....
First Name(s):	Relationship to child:	Relationship to child: .....
Surname:		
Address:	Address (if different from child)	Address (if different from child)
.....	.....	.....
	.....	.....
Postcode:	Postcode:	Postcode: .....
Telephone:	Telephone:	Telephone: .....
Email address:	Holds parental responsibility? Yes / No	Holds parental responsibility? Yes / No
	If no, please provide details of who does hold	If no, please provide details of who does hold
	responsibility:	responsibility: .....
	.....	.....

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

Language(s) spoken by child: .....
Language(s) spoken by parent/carer: .....
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 <u>home</u> language? If yes, please give details;
.....
Religion: .....

Ethnic Origin (Please tick)

	White British	(A)		Other mixed	(G)		Black African	(N)
	White Irish	(B)		Asian- Indian	(H)		Other Black	(P)
	Other White	(C)		Asian- Pakistani	(J)		Chinese	(R)
	White & black Caribbean	(D)		Asian- Bangladeshi	(K)		Other Ethnic group	(S)
	White & black African	(E)		Other Asian	(L)			
	White & Asian	(F)		Black Caribbean	(M)		Not stated	(Z)

Known / referred to other Professionals;
(please tick)

- ○ Audiology
- ○ CIASS
- ○ LAWSS
- ○ 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 Statement / EHCP? Y N

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

.....
.....
.....

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

Swallowing/feeding concerns	

What would you like to achieve from this referral?

.....
.....
.....

We will share information with other health professionals as appropriate
I give consent

- to an assessment by the Speech and Language Therapy Service as appropriate for my child **Yes / No**
- for my child to be seen in school/nursery (face to face or virtually) even if I am unable to be present **Yes / No**
- for my child to be seen by a SLT student under the supervision of a qualified SLT **Yes / No**
- for information to be shared with other professionals (inc. local authority) **Yes / No**
- for information to be communicated between any independent speech and language therapists (SLTs) who are involved with my child and the NHS SLT service **Yes / No**
- for my child to be photographed / videoed for clinical purposes **Yes / No**
- for staff at my child's nursery/school/other professionals to request further appointments for my child on my behalf **Yes / No**
- to be contacted via:
  - * email **Yes / No**
  - * text message **Yes / No**
  - * voice mail messages **Yes / No**

Signed: ..... (Parent/guardian) Print Name:.....

Date: .....

You can access our website for general information and waiting times at the following address
www.coventrychildrensslt.co.uk

Please note: referrals will only be accepted if the child or young person is registered with a Coventry GP

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