# Speech and Language Therapy Dysphagia Referral Form

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|---|---|
| **Patient name:** | **D.O.B:** |
| **Address:** | |
| **Telephone no:** | **N.O.K telephone no:** |
| **GP Surgery:** | **Referral date:** |
| **Referrer name:** | **Referrer telephone no:** |
| **Current diagnosis:** | |
| **Previous Medical History:** | |

***Current Dysphagia Recommendations***

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|---|
| **Fluids:** Normal ☐ 'Naturally thick ☐ Stage 1 ☐ Stage 2 ☐ stage 3 ☐ |
| **Diet:** Normal ☐ 'Thin Puree (B) ☐ Thick Puree (C) ☐ Pre mashed (D) ☐ Fork mashable (E) ☐ |
| **Non Oral:** PEG/RIG ☐ NG ☐ |
| **Is the patient feeding 'at risk?'** Yes ☐ No ☐ Not known ☐ |

| **Background Information –** *please complete all fields* | **Yes** | **No** |
|---|---|---|
| Does the patient have a current chest infection? | | |
| Does the patient have recurrent chest infections? | | |
| Is the patient receiving 'active' care? | | |
| Is the patient receiving 'palliative' care? | | |
| Can the patient maintain alertness for more than 10 minutes? | | |
| Has the patient had any unintentional weight loss due to dysphagia? | | |

| **Dysphagia Checklist – please** *(please complete all fields)* | **Never** | **More than once** | **Often** | **Always** |
|---|---|---|---|---|
| Coughing during or after eating/drinking | | | | |
| Choking during or after eating /drinking | | | | |
| Change in voice quality – 'gurgly' or wet voice when speaking | | | | |
| Gasping for breath at mealtimes | | | | |
| Change of colour in the face when eating/drinking | | | | |
| Nasal regurgitation (food coming down the nose) | | | | |
| Difficulty maintaining a clean mouth and teeth | | | | |
| Taking a long time t o eat (more than usual) | | | | |
| Recent difficulty swallowing tablets | | | | |
| Increased drooling of saliva/food/fluid | | | | |
| Pieces of food found inside the mouth | | | | |
| Evident or suspected discomfort when swallowing | | | | |
| Sounds of respiratory difficulty during or after eating | | | | |
| Diagnosis of reflux | | | | |
| Urinary Tract Infections | | | | |

Additional Comments:

**Please complete this form in full and fax to 020 8390 6923 along with any relevant documents**

*Incomplete forms will be returned to the referrer as they may result in your patient being inappropriately prioritised and will delay our response time*