Please send all referrals for Learning Disabilities to: [Learning Disability Service - Oxford Health NHS Foundation Trust](https://www.oxfordhealth.nhs.uk/learning-disability-service/)

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| --- |
| **Personal Details Date of referral**  |
| \*Patient name: | \*Date of Birth: \*NHS Number: |
| \*Address:Floor/unit |  |
|  | Next of Kin/alternative contact:Relationship to patient: Telephone number: |
| \*Home No.:   | \*GP Practice: |
| Mobile No.: |  |
| \* First Language:  | Is an interpreter needed Yes [ ]  No [ ] If yes, specify language and dialect: |
| \*Resuscitation Status: |
| Social situation:\*Any known risks to staff? |
| \*Has the patient consented to referral? Yes [ ]  No [ ]  Best interests [ ]  |
| **Outpatient clinic/digital appointments are offered as first appointment** **All face-to-face appointments will be held in clinic unless patient is bedbound or housebound**\*Is the patient bedbound/housebound: Yes [ ]  No [ ] \*Email address (for digital consultation): |
| \*Medical History, **including food allergy:*****Please attach any recent relevant reports from consultants/investigations relating to the client’s condition e.g. neurologists, videofluoroscopy, gastroenterologist/barium swallow, ENT*** |
| **Referral Details**  |
|  \*Reason for referral:[ ]  Swallowing[ ]  Communication[ ]  Swallowing and communication |
| **Swallowing** (only complete this section if referral is for a swallowing difficulty) |
| Sudden onset [ ]  Gradual decline [ ]  Rapid decline [ ] **Current recommendations / oral intake:** Oral intake [ ]  Nil by Mouth [ ]  PEG [ ]  |
| **Diet:** [ ]  Level 7, Regular [ ]  Level 7 Regular; Easy-to-chew[ ]  Level 6, Soft & Bite-sized [ ]  Level 5, Minced & Moist [ ]  Level 4, Puree [ ]  Level 3, Liquidised  | **Fluids:** [ ]  Level 4, Extremely Thick[ ]  Level 3, Moderately Thick[ ]  Level 2, Mildly Thick[ ]  Level 1, Slightly Thick[ ]  Level 0, Thin ( ie. Normal drinks ) *Please refer to IDDSI framework if unsure -* [*IDDSI - International Dysphagia Diet Standardisation Initiative*](https://iddsi.org/) |
| \***Coughing on food**  | Occasionally *(1-3 times per week)* [ ]   | Once a day [ ]   | Every meal [ ]   | Most mouthfuls [ ]   |
| \* **Coughing on fluids**  | Occasionally *(1-3 times per week)* [ ]   | Once a day [ ]  | Every drink [ ]   | Most mouthfuls [ ]   |
| \*Chest infections treated with antibiotics (in the last six months)\*Choking episodes on food: *Complete obstruction of the airway that may have required back slaps or abdominal thrusts****.*** *A person who is choking cannot breathe, cough or talk whilst choking*Mouth holding, spitting out food, food or drink refusal \*Significant weight loss related to swallowing difficulty \*Drinking significantly less than usual due to swallowing difficulty  | Yes [ ] No [ ] Yes [ ] No [ ]  [ ]  [ ] [ ]  | \*Dates:\*If ticked, on what and when did they choke:  |
| Any further details about swallowing: |
| Communication (only complete this section if referral is for a communication difficulty)  |
| Sudden onset [ ]  Gradual decline [ ]  Have they received any previous LSVT or LOUD Therapy [ ] Is there a diagnosis of dementia?Difficulty understanding what is said to them [ ] Difficulty finding words/speaking in sentences Slurred or unclear speech [ ] Stammering [ ] Changed voice quality e.g. hoarse, quiet [ ] Other ***N.B if client is being referred for specific voice difficulties, they must have had a recent ENT assessment (within 6 months). Please attach report.*****Please note - We do not accept referrals for developmental difficulties e.g. lisps, dyslexia, dyspraxia, dyscalculia, communication difficulties related to dementia (including Primary progressive Aphasia) or Gender affirming voice therapy**  |
| Any further information: |
| **\*Name of referrer:** | **Job Title/Relationship:** |
| **\*Contact no.:** |  |
| **Address:**  |

PLEASE RETURN ALL 3 PAGES TO: **Email:** **AdultSLT@oxfordhealth.nhs.uk**
Post: Adult SLT, East Oxford Health Centre, Manzil Way, Oxford, OX4 1XD 01865 904193