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**](mailto:AdultSLT@oxfordhealth.nhs.uk)  
Post: Adult SLT, East Oxford Health Centre, Manzil Way, Oxford, OX4 1XD 01865 904193