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**CHILDREN’S SPEECH AND LANGUAGE THERAPY**

**FEEDING REFERRAL FORM**

**FOR COMPLETION BY PROFESSIONALS**

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| **BEFORE PROCEEDING WITH THIS REFERRAL –**   1. **REFERRAL FOR BABIES/CHILDREN WHERE THERE IS CONCERN ABOUT SAFETY OF SWALLOW AND/OR ORAL-MOTOR FEEDING DIFFICULTIES, OR CHILDREN UNDER 18 MONTHS WITH SENSORY-AVERSIVE FEEDING ISSUES – SEE CSLT DYSPHAGIA THRESHOLDS DOCUMENT FOR FURTHER INFORMATION. THE GUIDELINES CAN BE LOCATED IN THE FEEDING DIFFICULTIES SECTION OF OUR WEBSITE AT:** [**www.leedscommunityhealthcare.nhs.uk/cslt**](http://www.leedscommunityhealthcare.nhs.uk/cslt) 2. **LEEDS COMMUNITY HEALTHCARE PROFESSIONALS SHOULD ACCESS REFERRAL FORM VIA SYSTMONE** 3. **ALL OTHER PROFESSIONALS SHOULD COMPLETE REFERRAL AS BELOW** 4. **IF YOU ARE UNSURE WHETHER THIS REFERRAL IS APPROPRIATE, PLEASE CALL 0113 843 2760 TO DISCUSS WITH KIRSTY WALLACE (CLINICAL LEAD) OR E-MAIL kirsty.wallace6@nhs.net** |

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| **PLEASE NOTE THAT WE REQUIRE PARENT/CARER CONSENT FOR THIS REFERRAL** | | | | |
| **PARENT/CARER CONSENT DISCUSSED AND OBTAINED:** | **YES** |  | **DATE** |  |
| **PARENT/CARER CONSENT TO RECEIVE SMS TEXT APPOINTMENT REMINDER MESSAGES:** | **YES** |  | **NO** |  |

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| **DETAILS OF CHILD BEING REFERRED:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FIRST NAME:** | | | |  | | | | | | | | | | | | | | | | | **SURNAME:** | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **NHS NO:** | |  | | | | | | | | | | | | | | | **DOB:** | |  | | | | | | | | | | | | **GENDER:** | | | | | | | | |  | | | | | | | |
| **ADDRESS:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | **POSTCODE:** | | | | | | | | | | |  | | | | | | | | | | | | |
| **CONTACT TEL NOs:** | | | | | | **HOME:** | | | | | | |  | | | | | | | | | **MOBILE:** | | | | | | | | |  | | | | | | | | | | | | | | | | |
| **PARENT/CARER NAME(S):** | | | | | | | | |  | | | | | | | | | | | | | | | | | | **RELATIONSHIP:** | | | | | | | | | | |  | | | | | | | | | |
| **GP NAME/PRACTICE:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **GP ADDRESS:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **GP TEL NO:** | | | | | |  | | | | | | | | |
| **HV / SCHOOL NURSE NAME:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HV / SCHOOL NURSE BASE:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | **TEL NO:** | | | | | |  | | | | | | | | |
| **OTHER AGENCIES/ PROFESSIONALS INVOLVED? PLEASE SPECIFY:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DOES THE CHILD ATTEND A SETTING EG SCHOOL, NURSERY, CHILDREN’S CENTRE?**  **IF YES, PLEASE GIVE DETAILS BELOW:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **YES** | | | | | |  | | **NO** | | |  |
| **SETTING NAME:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SETTING ADDRESS:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SETTING TEL NO:** | | | | |  | | | | | | | | | | | | | | | | **KEY WORKER NAME:** | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| **DAYS WHEN CHILD ATTENDS SETTING:** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DETAILS OF ANY PREVIOUS SLT INVOLVEMENT. PLEASE SPECIFY:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **KNOWN DIAGNOSED MEDICAL CONDITIONS/**  **MEDICAL ISSUES. PLEASE SPECIFY:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CURRENT MEDICATION.**  **PLEASE SPECIFY:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ARE THERE ANY CONCERNS ABOUT GROWTH** | | | | | | | | **YES** | | | |  | | | | **IF YES, PLEASE SPECIFY:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NO** | | | |  | | | |
| **LANGUAGE(S) SPOKEN AT HOME:** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IS AN INTERPRETER REQUIRED?** | | | | | | | | | | **FOR PARENT/CARER** | | | | | | | | **YES** | |  | | | **NO** | |  | | | | **FOR CHILD** | | | | | | | | **YES** | | | | | |  | | **NO** | |  |
| **If YES – PLEASE INCLUDE SPECIFIC REQUIREMENTS EG GENDER OF INTERPRETER, WHICH LANGUAGE/DIALECT:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ARE THERE ANY SAFEGUARDING CONCERNS REGARDING THIS CHILD/FAMILY?**  **IF YES, SLT WILL CONTACT REFERRER** | | | | | | | | | | | | | | | | | | | | | | | | | | **YES** | | | |  | | | | **NO** | |  | | | | | **NOT KNOWN** | | | | |  | |
| **REASON FOR FEEDING REFERRAL AND ADVICE GIVEN SO FAR:**  **Please read referral guidelines over leaf before making your referral.** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PARENT/CARER VIEWS:** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **For Health Professionals Only: MOST RECENT DEVELOPMENTAL CHECK INFORMATION:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DATE:** |  | | | | | | **RESULT:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **DETAILS OF MEDICAL CONSENT (Consent can be verbal eg on phone)** | | | |
| **MEDICAL PRACTITIONER:** |  | | |
| **TITLE:** |  | | |
| **BASE:** |  | | |
| **E-MAIL:** |  | | |
| **TELEPHONE NUMBER:** |  | | |
| **DATE CONSENT OBTAINED:** |  | **NB PAEDIATRICIANS ONLY:** Do you give consent for VFSS referral if needed? | **Yes/ No** |

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| **DETAILS OF REFERRER:** | |
| **NAME:** |  |
| **DESIGNATION:** |  |
| **BASE:** |  |
| **E-MAIL:** |  |
| **TELEPHONE NUMBER:** |  |
| **DATE:** |  |

**LEEDS COMMUNITY HEALTHCARE STAFF SHOULD COMPLETE THIS REFERRAL FORM VIA SYSTMONE AND TASK TO:**

**ADMINISTRATION, LEEDS COMMUNITY CHILDREN’S SPEECH AND LANGUAGE SERVICE**

**ALL OTHER AGENCIES SHOULD COMPLETE THE FORM AND SEND TO:**

**CHILDREN’S SPEECH AND LANGUAGE THERAPY ADMIN SERVICE**

**Leeds Community Healthcare,**

**Building 3 White Rose Park**

**Millshaw Park Lane**

**Leeds**

**LS11 0DL**

**IF YOU HAVE ANY QUERIES PLEASE CONTACT THE CHILDREN’S SPEECH AND LANGUAGE THERAPY ADMIN TEAM -**

**TEL: LEEDS (0113) 843 3650.**

**WE WILL CONTACT YOU IF THIS REFERRAL FORM IS NOT FULLY COMPLETED AND/OR WE REQUIRE MORE DETAIL.**

**PLEASE NOTE WE AIM TO OFFER INITIAL APPOINTMENTS WITHIN 4 WEEKS OF THE CHILDREN’S SLT SERVICE RECEIVING THIS REFERRAL.**

# Children’s Speech and Language Therapy Service

# 

Dysphagia/Feeding and Swallowing in Children

## Who we see?

The CSLT CFT/ dysphagia team will see infants and children with feeding and swallowing difficulties (dysphagia) who fall into the following categories

1. Concern about swallow safety/aspiration, and/or significant oral motor delay/disorder affecting ability to manage food bolus
2. Children up to 18 months who have sensory aversive responses to food/fluid/touch around mouth

### If you are not sure whether to refer:

1. Find out as much as you can by asking questions about
   * Onset of the problem and feeding history
   * Typical day’s intake – textures/types of food/drinks and rough amounts
   * How long the mealtime takes
   * Pattern of growth
   * Any sensory problems eg. reluctance to have teeth brushed/get messy
   * Health – esp. any chest infections.
2. Observe the child having food/drink
   * Are sucking, biting, chewing skills (oral motor) appropriate for age/ delayed/ unusual?
   * Does food/drink re-emerge?
   * Are there any signs of aspiration/unsafe swallow?
   * How keen is the child to eat/drink

**If observation shows any of the following:**

* Signs of aspiration eg frequent coughing/spluttering/gagging/choking, history of chest infections; wet, “ruttly” sounding breath or voice; colour changes to skin, lip, nail beds; breathlessness; eye watering; grimacing, /rapid blinking/pulling back
* Clear oro-motor feeding difficulties such that child cannot suck/bite/chew etc at level appropriate for age
* Sensory-aversive behaviours around food/drink in a child under 18 months

**refer the child to the Community Feeding Team**

## If observations show any of the following:

* Food refusal/picky eating/rigid food behaviours/restricted intake due to choices
* Emotional/behavioural issues around food and mealtimes
* Lack of awareness of or response to child’s cues by feeder (eg force feeding)
* Mild delay in moving through textures

refer the child to **local health visitor** for further observation/advice and for consideration of onward referral (eg to Pediatrician/Growth and Nutrition Team)

If you have any doubts ring the Community Feeding Team - Kirsty Wallace (Clinical lead), Liz Franklin, Jenn Long, Trish Hilton, Caroline Watson, Olivia Gould, Katy Woolgar on 0113 8432760