To ensure timely action of this request, please complete as fully as possible.

SPEECH AND LANGUAGE THERAPY REQUEST FOR ASSISTANCE

General information:	
Client name:	****Date of birth/CHI:**
Current location:	Contact number:
Diagnosis/relevant medical conditions:	Next of kin name & contact no:
For CPR?: Yes ☐ No ☐	Is the patient or their POA agreeable to request?

Capacity status:
Has capacity ☐ AWI ☐ POA/Guardianship ☐

Who is concerned?:
Patient concerned ☐ Family concerned ☐ Staff concerned ☐

Current care plan:
Anticipatory care plan ☐ Palliative care ☐ Alternative nutrition discussed ☐

Reason for request:
Swallow ☐ Communication ☐ Both ☐

Swallowing difficulties: ***Please tick the boxes that best describe what you have observed***

1.	2.	*Delete as appropriate*		
Acute onset ☐	Coughing/choking ☐	Weight loss	Y	N
Gradual deterioration ☐	Gurgly voice ☐	Chest infection	Y	N
Longstanding ☐	Pocketing/pouching ☐			

Current diet:	**Current fluids:**
Level 7, Regular ☐	Level 0, Thin ☐
Level 6, Soft and Bite-sized ☐	Level 1, Slightly Thick ☐
Level 5, Minced and Moist ☐	Level 2, Mildly Thick ☐
Level 4, Pureed ☐	Level 3, Moderately Thick ☐
Level 3, Liquidised ☐	Level 4, Extremely Thick ☐

What has changed / what is already helping?:

Communication difficulties: ***Please tick the boxes that best describe what you have observed***

Understanding others ☐ Reading ☐ Writing ☐

Finding words ☐ Slurred speech ☐ Quiet voice ☐

Other (please state):

What has changed / what is already helping?:

Name of referrer:
Designation:

Date sent:	**Email to: Fife-UHB.FifeSLTReferral@nhs.net**

****REQUEST WILL <u>NOT</u> BE ACCEPTED IF CHI/DATE OF BIRTH IS NOT PROVIDED**