**Children’s Speech and Language Therapy Referral Form – Feeding Difficulties**

Referrals can be made by anyone **providing there is parental consent. The person making the referral must observe the child/young person eating and drinking in order to complete the form accurately.**

Young people assessed to be competent by the referrer are able to give consent themselves for this referral.

Please complete all sections in **black ink/ Black type**. Any forms which are illegible will be returned to the sender.

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| **Surname: First Name: DOB:** **Pre-term Baby/ Infant? Born at:** **NHS No. (if known)**  **Male/ Female:** **Address: Postcode: Protected Address?:** **Child living with: Further information:** **Parent/Carer 1 Full Name: Parent/Carer 2 Full Name:** **Parent/Carer 1 contact No: Parent/Carer 2 contact No:** **Alternative Number: Alternative Number:** **GP: Health Visitor: School Nurse:** **Pre-school/ School provision: Home Language/s:****Is interpreter required: Parental consent for interpreter:** **Religion: Ethnicity:**  |
| **Are there any safeguarding issues?: Child is on a**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **plan** (if applic)**Further information:** **Are other agencies involved?:** **Current referrals to other agencies e.g. early help, physio etc****Current and Past Medical information:** **Is infant/ child currently on any reflux medication/ reflux is being investigated?:** Yes No **Does Infant/ Child currently have Nasogastric Tube/ PEG in situ?** Yes No **When did identified eating/ drinking/ swallowing difficulties start?**  |
| **The referrer MUST observe the infant or child feeding/ eating and drinking before completing this section.****FEEDING SKILLS** (if applicable):1. **Current feeding regime: (Breast/ bottle or combined?):**
2. **Frequency and duration of Breast/ Bottle feeds:**
3. **Current formula/ milk used:**
4. **Current bottle type and level of teat used (if applic.):**
5. **Current concerns about feeding:**
6. **Do any of the following symptoms occur during feeding?**

Gurgly voice [ ]  Arching back [ ]  Vomiting [ ]  Gasping [ ]  Choking\* [ ]  Breathlessness [ ]  Changing colour [ ]  Eye tearing [ ]  Sudden sweating [ ]  Coughing [ ] Arms and legs extending [ ]  Eyes widening [ ]  Frowning or grimacing [ ] \*If parents/ carers have reported choking, the referrer MUST ensure this has been true choking (e.g. not able to breath, choking interventions needed e.g. back slaps, chest thrusts 999 call, resuscitation) **rather than gagging** 1. **Are there any concerns about the infant’s weight gain?:**
2. **Additional information about past/ current feeding skills:**
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| **EATING SKILLS** (if applicable):1. **What foods are typically eaten?:**
2. **What foods / textures are the most difficult for the child?**:
3. **What happens when the child eats these difficult foods?:**
4. **Do any of the following additional symptoms occur when eating?:**

Gurgly voice [ ]  Arching back [ ]  Vomiting [ ]  Gasping [ ]  Choking\* [ ]  Breathlessness [ ]  Changing colour [ ]  Eye tearing [ ]  Sudden sweating [ ]  Coughing [ ] *\*If parents/ carers have reported choking, the referrer MUST ensure this has been true choking (e.g. not able to breath, choking interventions needed e.g. back slaps, chest thrusts, 999 call, resuscitation)* ***rather than gagging***1. **How long does it take for the child to eat a typical meal?:**
2. **Are there any concerns about the infant/ child’s weight gain?:**

**Has your health visitor provided any support around eating and mealtimes?** *(This could have involved general advice about weaning, mealtime routines, mealtime seating and positioning, behaviour/ environment/ distractions at mealtimes etc).* **If so please given details:**1. **Additional information about past/ current eating skills:**
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| **DRINKING SKILLS** (if applicable)**:**1. **What does the child drink?:**
2. **What sort of cup does the child use?**:
3. **Does the child have difficulty sucking?**: Yes [ ]  No [ ]
4. **How long does it take them to have a drink?:**
5. **Has the child previously used thickener in their drinks?** Yes [ ]  No [ ]
6. **Do any of the following additional symptoms occur when drinking?:**

Gurgly voice [ ]  Arching back [ ]  Vomiting [ ]  Gasping [ ]  Choking\* [ ]  Breathlessness [ ]  Changing colour [ ]  Eye tearing [ ]  Sudden sweating [ ]  Coughing [ ] *\*If parents/ carers have reported choking, the referrer MUST ensure this has been true choking (e.g. not able to breath, choking interventions needed e.g. back slaps, chest thrusts, 999 call, resuscitation)* ***rather than gagging***1. **Are there any concerns about the child’s hydration levels?:**
2. **Additional information about past/ current drinking skills:**
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| Has the infant/ child had any **past chest infections** that needed antibiotics from the GP/Paediatrician? Yes [ ] No [ ] If so please give further information including dates: Has the infant/ child had any **recent chest infections** that needed antibiotics from the GP/Paediatrician? Yes [ ] No [ ] If so please give further information including dates:  |
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| **LEVEL OF CONCERN:** (‘0’ being no concern, ‘7’ being extremely concerned)**Level of parental concern:** **Level of referrer’s concern:** **Level of child/ young person’s concern** (if applicable) **Has the child been referred to Speech and Language Therapy for feeding difficulties before?:** Yes [ ]  No [ ]  Unknown [ ] **Please provide any further information you think may be helpful to us:**  |

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| **I have discussed the child’s difficulties with their parent/ guardian and advised it may be necessary to seek further information from other professionals involved prior to initial assessment (if relevant).** **Discussed with: Relationship to child:** **Parent/ Guardian’s signature: Consent has been given verbally:** [ ] **Name of referrer: Designation:** **Referrer’s contact No: Date:** **Referrer’s location/Base:**  |

THIS INFORMATION IS ESSENTIAL, IF NOT FULLY COMPLETED THIS FORM MAY BE RETURNED TO YOU RESULTING IN A DELAY. PLEASE COMPLETE ALL SECTIONS AND RETURN BY:

**EMAIL:** **ghnt.specialneedssalt@nhs.net**

 **NB: Emailed referrals will only be accepted from a secure email address, e.g. nhs.net / .gov.uk**

**OR**

**Post: Speech and Language Therapy Dysphagia Service, Department of Speech and Language, Bensham Hospital, Saltwell Road, Gateshead, NE8 4YL (Tel: 0191 445 6667)**

Data Protection

Any personal information is kept confidential. There may be occasions where your information needs to be shared with other care professionals to ensure you receive the best care possible.

In order to assist us to improve the services available, your information may be used for clinical audit, research, teaching and anonymised for National NHS Reviews and Statistics. Further information is available via Gateshead Health NHS Foundation Trust website or by contacting the Data Protection Officer by telephone on 0191 445 8418 or by email ghnt.ig.team@nhs.net.

 **This form can be made available in other languages and formats upon request**