SLT Referral For Swallow Assessment of Nursing Home Residents

FRESENIUS KABI

Resident Name	
Resident DOB	
Nursing Home name	
Name of referrer and job title	
Date of referral	
Telephone number	
Email address	
Medical History	

Consent
Please select as appropriate:

- ☐ The resident has consented to this referral
- ☐ The referral has been made in the resident's best interests

Is the resident taking any medication that is affecting their swallow?	☐ Yes	☐ No
*If Yes, please state what form:		
Or causing the following:		
Drowsiness	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No

Current diet and fluid regime Method of intake:	☐ Oral feeding/drinking	☐ PEG/RIG	☐ PEG/RIG + Oral

Fresenius Kabi Ltd
Unit 3B Fingal Bay, Balbriggan, Co. Dublin, Ireland
www.fresenius-kabi.ie
IE-FKEN-2400026
Date of Preparation: March 2024

Current swallow recommendations

☐ Never previously assessed

If previously assessed: SLT name: Date:

FOOD	LIQUID
☐ **Level 7:** Regular	☐ **Level 0:** Thin
☐ **Level 7a:** Regular Easy to Chew	☐ **Level 1:** Slightly Thick
☐ **Level 6:** Soft and Bite-Sized	☐ **Level 2:** Mildly Thick
☐ **Level 5:** Minced and Moist	☐ **Level 3** Moderately Thick
☐ **Level 4:** Pureed	☐ **Level 4:** Extremely Thick
☐ **Level 3:** Liquidised	

Clinical indicators that SLT assessment is required:

Please select:

- ☐ Difficulty chewing
- ☐ Coughing on fluids
- ☐ Coughing on food
- ☐ Nasal regurgitation
- ☐ Prolonged feeding time
- ☐ Spillage of drinks
- ☐ Drooling of saliva
- ☐ Holding fluid/food in the mouth
- ☐ Choking on food (airway fully/partially obstructed)
- ☐ Choking on fluid (airway fully/partially obstructed)
- ☐ Recurrent chest infections
- ☐ Requires backslaps/abdominal thrusts when choking on flood and fluids

Is the Dietitian involved?	☐ Yes	☐ No
Is there a history of weight loss?	☐ Yes*	☐ No
*If so please document weight, BMI and MUST:		
Is the patient currently eating with acknowledged risk*	☐ Yes	☐ No
Is this patient receiving End of Life care?	☐ Yes	☐ No

*Risk feeding is the term used when a patient continues to eat and drink orally despite risks [RCSLT], 2005)

For residents not following SLT recommendations

Please select:

Does the resident have capacity, i.e. can understand, weigh up and communicate (verbally or non-verbally) the risks of not following recommendations	☐ Yes	☐ No

NB All health professionals are qualified/have a duty to assess capacity

- If the resident has capacity, it is their right to decline the recommendations. Document your assessment and the resident's decision clearly in care plan.
- If the resident does not have capacity then the nursing home needs to make/facilitate a 'best interest' decision (involve GP if necessary).

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By sending this referral I understand:

The resident (or referrer if the resident is unable to give informed consent) understands & acknowledges that their personal information will be securely used, stored and shared in order to provide ongoing clinical care.

- The information obtained by this form will be used for the purposes of therapeutic assessment only and will not be used by any other party. For more information on how we use this data please click here.
- This is not an emergency service.
- Assessments may be carried out remotely or in house, as decided by the SLT following triage of the referral.
- Incomplete referrals will be returned and may delay assessment time.

Referrer name: **Date:**

Please review the form before signing.

PRINT FORM

Save this form and send it to:
SLTreferrals@fresenius-kabi.ie

SAVE AND SEND FORM