**Requester details**

**Dysphagia / Feeding and Swallowing**

* **Request for Assessment**

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| Name: | Address / contact number / email address: |
| Job Title: |
| By submitting this request: You confirm that you have discussed this request for assessment with the parent / guardian and that they have given their express consent to this request for assessment. You are aware and have explained to the parent/guardian that this request for assessment is subject to triage and that the child may be signposted to another agency better able to meet the child’s needs, or further information may be requested before the referral to the service is accepted. |

**Child/Young Person’s details**

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| --- | --- |
| Name: | Date of birth: |
| Gender: | NHS number: |
| Address: | GP: |
| Parent/Guardians: Please provide name/address/contact numberParental responsibility? **Yes / No** | Languages spoken at home:Interpreter required?  **Yes / No**Has the child been seen by Speech and Language Therapy before/elsewhere? **Yes / No****Please provide copy of feeding plan / latest report if so.** |

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| Please tick if the child is subject to any of the following?* Child Protection Plan
* EHFS Plan (Early Help Family Support Plan)
* CIN action plan (Child In Need)
* TAF action plan (Team Around the Family
* Looked After Child
 |
| If ‘**yes**’ to the above please provide name and contact details of key persons: |
| Please provide **names** and **contact information** of other professionals involved, e.g. physiotherapy, occupational therapy, dietetics etc.: |
|  |  |
| **School / Nursery:**  |

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| Medical diagnosis (if known): |
| Birth history (including gestation, weight and support required, if known):  |
| Current medication:  |
| Allergies: |
| Any recent hospital admissions or investigations? Please provide details: |
| Reason for referral:  |
| **Does the child present with:**Recurrent chest infections Yes No Gastro-oesophageal reflux Yes No Concerns with weight gain Yes No **Circle those that are observed when the child is eating or drinking:** Wet voice / changes in breathing / arching back / blinking or eyes watering / changes in colour / frequent gagging / vomiting / frequent coughing **Current Method of Nutrition: (circle as appropriate):** Bottle/Breastfeeding; Oral – food and drink; NG tube; Gastrostomy; Other |
| Current food and drinks taken (including texture modifications); |
| Strategies currently in place:  |

**Please send completed form to: dysphagia@nca.nhs.uk**

**Criteria to access SLT Feeding and Swallowing service:**

* Children with physical difficulties with their feeding and swallowing.
* Children with neuromuscular conditions affecting their feeding and swallowing
* Children with genetic conditions / syndromes with recognised associated feeding and swallowing difficulties.
* Children with brain injury resulting in feeding and swallowing difficulties
* Children with metabolic conditions resulting in physical difficulties feeding and swallowing.
* Children with neurological conditions (including cancer) resulting in feeding and swallowing difficulties.

**We do not offer a service for the following:**

* Children with fussy / faddy eating difficulties.
* Children requiring weaning or developmental advice and / or support
* Children with food aversion resulting from gastro-oesophageal reflux (GOR)
* Children with sensory feeding difficulties e.g. children on the autistic spectrum
* Children requiring psychological support around mealtimes.