Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

Long Term Care
Speech-Language Pathology Referral

Resident Name:		MHSC #:
Primary Diagnosis:	Facility:	Room:
Family Contact Name:	Contact Phone: ___-___-____	Is Resident/Family agreeable to referral? ☐ Yes ☐ No

Reason for referral:

☐ Swallowing Assessment Referral

Diet Texture: _____

Fluid Consistency: _____

☐ **Urgent**

- ☐ **Recent choking event** **Date:** D D M M M Y Y Y Y
- ☐ **Recent pneumonia** **Date:** D D M M M Y Y Y Y
- ☐ **Recent change in neurological status** (please comment below)
- ☐ **Resident is recently NPO**

☐ Tube feed - request for assessment for oral feeding

☐ Return from hospital requiring follow-up

☐ Admitted on most restrictive diet texture (i.e., pureed/thickened fluid)

☐ Pleasure/comfort feeding assessment/discussion

☐ Assessment for upgrade of food/fluid

☐ Resident/family request

☐ Baseline swallowing assessment for those with a progressive neuromuscular disorder

☐ Indicators of swallowing difficulty
(Attach Meal Observation Screening if applicable)

☐ Communication Assessment Referral

☐ Sudden change in ability to communicate

☐ Dementia – functional communication assessment

☐ Family and/or staff education re: communication

☐ Communication device request e.g., Alternative Augmentative Communication (AAC) system

☐ Resident/Family request

☐ Other (please comment below)

Comments:

Referred by: _____ Phone: ___-___-____
PRINTED NAME AND DESIGNATION

Signature: _____ Date: D D M M M Y Y Y Y

Fax Completed referral to Speech-Language Pathology Service at 204-831-2953

Swallowing Assessment form Completion Guidelines

1.0 Form Purpose: To refer residents in Long Term Care to a Speech-Language Pathologist for a swallowing and/or a communication assessment.

2.0 Definitions:

2.1 Urgent – requires a quick (1-2 working days) response

2.2 NPO – "Nil per os", Latin for "nothing by mouth", meaning to withhold oral intake of food and fluids

2.3 Pleasure/Comfort Feeding: an approach to feeding and swallowing management for residents who have been judged to be at high risk of aspiration/choking and who wish to continue with an oral diet. Due to the severe nature of the dysphagia, the resident is not expected to meet nutrition/hydration needs through oral intake.

3.0 Used By:

Members of the health care team working in the Long Term Care setting

4.0 Guidelines for Completion:

4.1 Indicate type of referral (communication, swallowing or both): and whether swallowing concerns are urgent.

4.2 Complete the resident demographic information.

4.3 Indicate the primary medical diagnosis and the current diet texture that the resident is consuming.

4.4 Indicate the reason for the referral. Select all applicable check boxes, and supply additional details in the comments section as applicable.

Swallowing-related referrals:

4.4.1 **Recent choking event**: indicate date of the most recent choking event

4.4.2 **Recent pneumonia**: indicate date of most recent pneumonia

4.4.3 **Recent change in neurological status**: describe and reference to diagnostic reports, if needed

4.4.4 **Tube feed – requesting assessment for oral feeding**: the resident is NPO, and request for an assessment to determine safety for food and/or fluid by mouth is needed.

4.4.5 **Return from hospital requiring follow up**:

- the resident was seen by a SLP in the hospital with a change to the previous diet texture
- the resident's diet texture was changed in the hospital without SLP involvement
- there was a change in the medical status/condition of the resident after return to Long Term Care

4.4.6 **Baseline swallowing assessment**: check this box to request a swallow assessment for residents with a progressive neuromuscular disorder such as Parkinson's disease, Parkinson's Plus Syndromes (Progressive Supranuclear Palsy, Multi-Systems Atrophy, Cortico-basal Degeneration, and Dementia with Lewy Bodies), Multiple Sclerosis, Huntington's disease, and ALS (Amyotrophic Lateral Sclerosis).

Communication-related referrals:

4.4.7 **Sudden change in ability to communicate** - this may involve a sudden neurological event, such as a stroke.

4.4.8 **Communication device request**, e.g., Alternative Augmentative Communication (AAC) system- the assessment and provision of a communication system that supplements or replaces the ability to verbally communicate.

4.5 Indicate who initiated the referral. Add signature, date and phone contact.

5.0 Filing/Routing Instructions:

5.1 Fax the completed referral to the Long Term Care SLP service at 204-831-2953.

5.2 File the original referral on the resident's health record.