

SPEECH-LANGUAGE THERAPY REFERRAL AND TREATMENT FORM

Adults

REFERRING INSTITUTION

Hospital / ward:	Bed no:
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1. FOR DOCTOR'S USE ONLY

1.1 PATIENT DETAILS

Surname and initials:	Patient ID /DOB: _____ Hospital No.: _____ Account number: _____
Address:	Tel. No: _____

1.2 CLINICAL INFORMATION

DIAGNOSIS & HISTORY:	Age:	Male	Female	Language preference
Medical History:				
Baseline Functioning:				
Medications:				
INVESTIGATIONS: Hearing Test: _____ Contrast Swallow: _____ CT Brain: _____ Brain MRI: _____ G-Scope: _____ Other: _____	TREATMENT REQUIRED:		Signature _____ Name (please print) _____ Qualification/Rank _____ Contact No: _____ Date _____ Time _____	

2. FOR SPEECH THERAPY USE ONLY

Referral received	Date:	Time:		
ST refers patient to other / additional health care professionals	Health care professional:	Date:		
Assistive device Issued	Device Type	Ordered	Date of Issue	F/U
Patient receives Government Grant	Yes	No	Type of grant:	
Patient / caregiver consent - treatment and risks - financial implications	Signature:		Date:	
	Interpreter required for consent:		Yes	No

3. ASSESSMENT/ OBSERVATION:

3.1 Problem Identified in:										Indicate: ✓ = Intact												
Attach specific assessment form										X = Not Intact												
Physical function			Neuro-motor function			Mental function			Sensory function										Respiratory function			
									Vision				Hearing				Pain		Skin			
									Tested:		Tested:		Tested:		Tested:							
3.2 Observations and Assessment Summary:																						
Health:			Medication						Operations						General Health							
Doctor						PT						OT						DT				
Previous Therapy																						
Communication (Speech) ✓ x			Verbal						Non-Verbal													
Language Changes:			Onset:						Progression of change:													
Level of Education									Employed: Y / N						Where? _____							
Responsibilities in work place									Are you planning on returning to work? Y / N													
Family / Social			Next of kin: _____						Relationship to patient:				Other:									
			Other family members:						Number of children:													
How has participation been affected?																						
What do you want to change most regarding speech / language?																						
3.3 Patient concerns:								Family concerns:								Patient/ family treatment Goal:						
3.4 Speech therapy treatment goal:																						

4. EDUCATION RECORD

W. Education Record		
Date	Education Topic	SLT Signature

ADULT SPEECH-LANGUAGE SCREENING FORM

General		Lateralisation			
Level of consciousness		<i>Velopharyngeal closure</i>		Reading	
Awareness of problem		<i>Diadokokinesis</i>		Numbers & letters	
Orientation		p, t, k		Words	
Attention		pt, tk, pk		Sentences	
Motivation		ptk		Instructions	
Communication		Speech		Passage	
Primary mode of communication		Rate		Writing	
Interest in participation		Fluency		Numbers & letters	
Initiation/topic maintenance		Clarity / intelligibility		Copying	
Eye-contact		Motor planning		Words	
Turn taking		Expressive language		Sentences	
Oral Motor Examination		Fluency		Feeding / Swallowing	
Facial Symmetry		Gestures		Current diet (consistency)	
Structural abnormalities		Automatic speech		Utensils	
Muscle tone		Naming objects		Spillage / drooling	
<i>Lip & cheeks</i>		Object descriptions		Signs of aspiration	
Lip spreading		Sentence formation		Voice	
Lip puckering		Discourse		Pitch	
Cheek puffing		Repetition		Quality	
<i>Tongue</i>		Receptive Language		Loudness	
Protrusion		Simple yes/no questions		Resonance	
Retraction		Abstract yes/no questions		Hearing	
Lateralisation		Following commands		Suspected HL	
Elevation		Object identification		Ototoxic medication	
Abnormal tongue pattern		Match objects to description		Pain or discharge	
Teeth		Sequencing		Noise exposure	
<i>Jaw</i>		Reasoning & logic			
Stability					
Opening & closing					

ADULT DYSPHAGIA SCREENING FORM

General		<i>Velopharyngeal closure</i>	Other:		
Level of consciousness		<i>Diadokokinesis</i>			
Awareness of problem		p, t, k			
Orientation		pt, tk, pk			
Attention		ptk			
Motivation		Oral Preparation / Oral Phase			
Management of Oral secretions			Liquids	Semi-Solids	Solids
Voice quality		No Cerebral recognition			
Oral Motor Examination		Anterior Spillage			
Facial Symmetry		Oral Residue:			
Structural abnormalities		Tongue			
Muscle tone		Floor of Mouth			
<i>Lip & cheeks</i>		Lateral Sulci			
Lip spreading		Palate			
Lip puckering		Nasal regurgitation			
Cheek puffing		Increased oral transit time			
<i>Tongue</i>		Premature Spillage			
Protrusion		Pharyngeal Phase			
Retraction			Liquids	Semi-Solids	Solids
Lateralisation		Increased pharyngeal transit time			
Elevation		Delay in trigger of swallow			
Abnormal tongue pattern		Signs of aspiration:			
Teeth		Coughing (during/after)			
<i>Jaw</i>		Throat clearing			
Stability		Wet/ gurgly voice			
Opening & closing		Drop in SpO ₂			
Lateralisation					
RECOMMENDATIONS					
Non-Oral feeds		Type	Techniques required:		
Oral Feeds		Diet			

5. DETAILED TREATMENT RECORD

[illegible]

