



SPEECH-LANGUAGE THERAPIST IN-PATIENT REFERRAL FORM

Unit Pemulihan Pertuturan-Bahasa, Jab ORL, HTM
Ext: 5149

A. PATIENT'S DETAILS

Name : _____
 I/C* : _____ Date of Referral* : _____
 Age : _____ Date of Admission : _____
 Ward* : _____ Bed: _____ Ward Ext Num*: _____
 Contact Num*: _____

B. CURRENT DIAGNOSIS*

C. MEDICAL DIAGNOSIS

<input type="checkbox"/> HPT	<input type="checkbox"/> DM	<input type="checkbox"/> Cardiac Problem	<input type="checkbox"/> Pulmonary Problem
<input type="checkbox"/> CVA	<input type="checkbox"/> TBI	<input type="checkbox"/> Dementia	<input type="checkbox"/> Parkinson
<input type="checkbox"/> Cancer (specify: _____)	<input type="checkbox"/> Degenerative Disease (specify: _____)		
<input type="checkbox"/> Down's Syndrome	<input type="checkbox"/> Cleft Lip/Palate	<input type="checkbox"/> Cerebral Palsy (specify: _____)	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Premature	<input type="checkbox"/> Other Syndrome (specify: _____)	
<input type="checkbox"/> Others (specify: _____)			

D. CT SCAN/MRI FINDINGS* (please stated **NA** if patient does not undergo this procedure)

E. CURRENT STATUS

GCS*: ____ /15 (patient at least **alert & conscious** for Clinical Bedside Swallowing Evaluation)

Feeding Mode: Oral NGT OGT PEG
 Tracheostomy: Uncuffed Cuffed → Inflated Deflated
 Intubation: Yes No
 Type of Oxygen Support: (specify: _____)
 Physical Condition: Ambulatory Non-Ambulatory → Wheelchair Bedridden

F. REFERRING PURPOSES*

ADULT	PAEDIATRIC
<input type="checkbox"/> Clinical Bedside Swallowing Evaluation	<input type="checkbox"/> Feeding & Swallowing Assessment
<input type="checkbox"/> Adult Language/Communication Assessment <i>Outpatient review only**</i>	<input type="checkbox"/> Paediatric Speech & Language Assessment <i>Outpatient review only**</i>

*Referral form will be rejected if this part * is left blank.

 (Doctor's Signature & Chop)*

Filled in by Receiving Staff

Date Received: _____

Time Received: _____



DYSPHAGIA SCREENING TOOL

Hospital Tanah Merah, Kelantan
Ministry of Health Malaysia

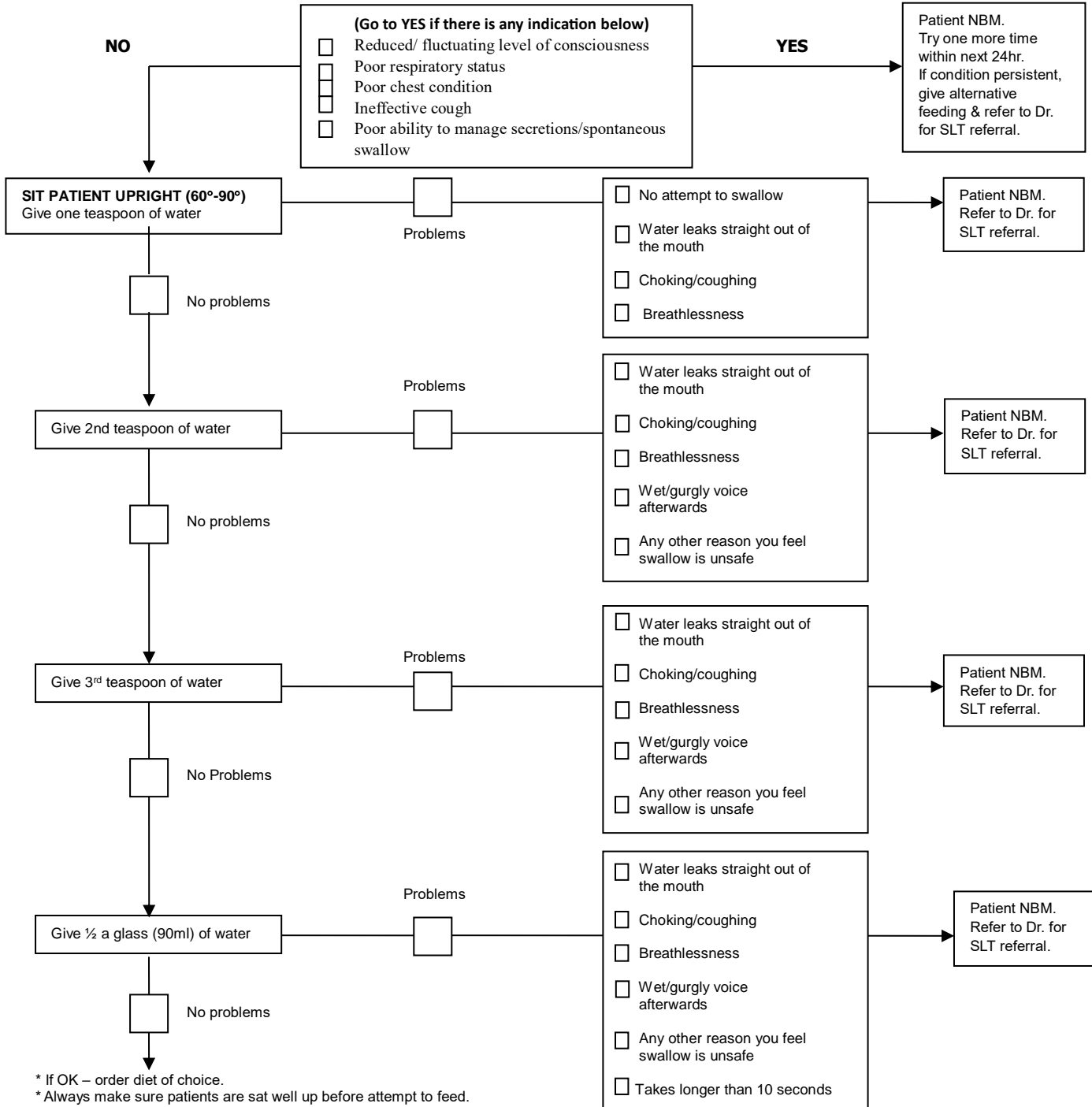
NAME, WARD, CONSULTANT

DATE : / /

TIME :

TRAINED ASSESSOR'S NAME :

*Gag reflex **DOES NOT INDICATE** patient's ability to safely swallow.



* If OK – order diet of choice.
* Always make sure patients are sat well up before attempt to feed.
* Observe patient eating the meal.
* Repeat assessment if the patient's condition DETERIORATES. Any concerns refer to Dr. for SLT referral.
* If no concerns, continue and maintain vigilance daily.

Refer to SLT: YES NO Date of referral: / / Doctor's signature:

NBM: Nil By mouth SLT: Speech-Language Therapist