N.J. Division of Developmental Disabilities, Olmstead Resource Team

SPEECH PATHOLOGY CONSULT

Please refer for issues with swallowing, mealtime behavior, weight loss, concerns regarding tube feedings,

problems with speech, communication, hearing or hearing aids.

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| --- | --- | --- | --- |
| Name: Click here to enter text. | DDD ID# Click here to enter text. | Date of Birth:Click here to enter text. | Residence Type (OH, GH, SA, etc.): Click here to enter text. |

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| --- | --- | --- | --- |
| Date of Referral: |   | Submitted By: | Click here to enter text. |

Demographics

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| --- | --- | --- |
|  | Residence | Day Program |
| Agency: | Click here to enter text.  | Click here to enter text. |
| Address: | Click here to enter text. | Click here to enter text. |
|  Phone: | Click here to enter text. | Click here to enter text. |
| Contact Person name/number | Click here to enter text. | Click here to enter text. |

Reason for Consult

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| **Choking Incident** (date):  |
| **Mealtime Safety** (check all that apply): [ ] Coughing/choking [ ] Unsafe eating (e.g. rapid rate)  [ ]  Preparation of modified food/drinks [ ] Meal refusal/weight loss  [ ] Explanation of medical reports (e.g. swallow study) [ ] Care of tube fed individual  [ ] Multiple choking incidents**Additional Information:** Click here to enter text. |
|  **Speech/Hearing/Communication** (describe): Click here to enter text. |

Dysphagia Risk Factors

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| **At-risk diagnosis** (check all that apply): [ ] Dysphagia [ ] Dementia [ ] Seizure Disorder [ ] GERD (stomach reflux disorder)  |
| **Other risk factors** (check all that apply): [ ] Over age 50 [ ] Positioning issues [ ]  Dental issues (including missing, broken, or refusal to wear dentures [ ]  Medications for seizures, anxiety, psychiatric disorders |

Supporting Documents

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| [ ]  Speech/Swallowing evaluations [ ]  IMFP, Meal Card or Meal Plan [ ]  Other pertinent assessments or plans |

Case Management/Support Coordination

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| --- | --- | --- | --- |
| [ ] CM [ ] SC Name:Email:  | Click here to enter text. | Phone Number: | Click here to enter text. |
| Supervisor Name:Email:  | Click here to enter text. |
| Guardian-relationship: | Click here to enter text. | Phone Number: | Click here to enter text. |
| Guardian’s email (if not BGS): | Click here to enter text. |
| Other Contact, if needed: | Click here to enter text. | Phone Number: | Click here to enter text. |

**To Be Completed by the Resource Team**

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| Rationale for Speech Pathology Assignment: | Click here to enter text. |
| Approved by:  | Click here to enter text. | Responsible Staff Person: | Click here to enter text. |

7/2018