N.J. Division of Developmental Disabilities Resource Team

SPEECH PATHOLOGY CONSULT

 Email completed form, as a Word document, to: DDD.ResourceTeam@dhs.nj.gov

Questions: Email DDD.ResourceTeam@dhs.nj.gov or call Katie Zappe at 609-984-5222.

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | MIS# |  |
| Date of Referral: |   | Submitted By:Title:  |  |

**Note:** We provide consultative services only, not direct therapy.

No clinical evaluations can be performed, and no therapeutic service can be provided.

If therapy is needed: We will suggest intervention from community providers. In addition, we will work with the IDT to coordinate all care staff and to document in the ISP

Reason consult is requested:

**MEDICAL:**

 [ ]  Weight loss (causing concern for malnutrition, dehydration, weakness)

**MEALTIMES/EATING/SWALLOWING:**

[ ] Choking incident (Follow up from an Incident Report)

[ ]  Train staff on preparing modified food and beverages.

[ ]  New mealtime behaviors (e.g. coughing during meals, positioning concerns)

[ ]  Unsafe eating behaviors (eating fast, distracted, lethargy, etc.)

[ ]  Assist with recommendation and explanations of swallow studies.

[ ]  Tube-fed care for consumers not eating orally.

 [ ]  Other (explain):

[ ] **ADDITIONAL INFORMATION**:

**OTHER:**

[ ]  Transition between residential settings with specific mealtime concerns requiring SLP follow up

 [ ]  Hearing aid care

 [ ]  Basic sign language

 [ ]  Other (explain):

Please indicate any potential risk factors below:

[ ]  Over age 50 – Age: \_\_\_\_

[ ]  Previous choking episode in the last 12 months

[ ]  Dx. of Dysphagia

[ ]  Dx. Dementia

[ ]  Dx. of Down Syndrome

[ ]  Dx. of Seizure Disorder

[ ]  Dx. of GERDS

[ ]  Positioning Issues

[ ]  At risk due to medications (seizure meds, anti- psychotic meds, sedating meds, etc.)

[ ]  At risk due to dental issues including refusal to wear dentures, broken dentures, etc.

[ ]  Behavior ([ ]  eating too fast [ ] stealing food [ ] PICA [ ] easily distracted)

Additional notes regarding the reason for the referral:

Support Coordination & Guardianship Information:

|  |  |
| --- | --- |
| SC name, email: |  |
| Guardian-relationship: |  |
| If not BGS, Guardian’s contact info: |  |

|  |  |  |
| --- | --- | --- |
|  |  Residence | Day Program |
| Agency: |  |  |
| Address: Street:City:  |  |  |
|  Phone: |  |  |
| Contact Person:  |  |  |

**To Be Completed by the Resource Team**

|  |  |  |  |
| --- | --- | --- | --- |
|  Choking Prevention Unit Approval Date: | Click or tap to enter a date. | Staff Person Assigned: |  |