N.J. Division of Developmental Disabilities Resource Team

SPEECH PATHOLOGY CONSULT

Email completed form, as a Word document, to: [DDD.ResourceTeam@dhs.nj.gov](mailto:DDD.ResourceTeam@dhs.nj.gov)

Questions: Email [DDD.ResourceTeam@dhs.nj.gov](mailto: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: |  |