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.

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

Reason consult is requested:

**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.

**MEDICAL:**

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

**MEALTIMES/EATING/SWALLOWING:**

Choking incident (Follow up from an Unusual 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):

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: |  |