# Dysphagia Speech and Language Therapy referral

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| --- | --- |
| Child’s name |  |
| Date of birth |  |
| NHS Number (if known) |  |
| Postcode |  |

Does the child present with a history of

|  |  |  |
| --- | --- | --- |
| Frequent coughing when eating/drinking? | Yes | No |
| Changes in breathing when eating/drinking? | Yes | No |
| Gagging when eating/drinking? | Yes | No |
| Vomiting when eating/drinking? | Yes | No |
| Gastro-oesophageal reflux? | Yes | No |
| Concerns over weight gain? | Yes | No |
| Recurrent chest infections? | Yes | No |