**Name: DOB:**

**Placement: Date Completed:**

Please use below questions to guide the decision whether an SLT assessment is required, and whether an assessment could potentially be carried out via telehealth.





  **YES**  **NO**



 **NO**

 **YES**

 **YES** **YES** 





 **NO**



 **YES**









\*\*All corresponding risk assessment forms to be completed with additional information\*\*

**Appendix 1:**

**Checklist for Clinical Indicators of a deterioration in swallow**

**Name: DOB:**

**Placement: Date Completed:**

Tick all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Don’t Know |
| 1. Regular and frequent episodes of coughing during or after meals
 |  |  |  |
| 1. Regular and frequent episodes of coughing during or after fluids
 |  |  |  |
| 1. Any choking episodes when eating
 |  |  |  |
| 1. Gurgly or wet voice quality after eating or drinking
 |  |  |  |
| 1. Does breathing sound different (e.g. ‘rattly’) or look distressing during or after eating / drinking
 |  |  |  |
| 1. Watery eyes whilst eating or drinking
 |  |  |  |
| 1. Any difficulties swallowing medication
 |  |  |  |
| 1. Any sudden weight loss
 |  |  |  |
| 1. Recurrent chest infections or is prescribed many regular courses of antibiotics
 |  |  |  |

**Completed by:**

Name: Role:

Date: