



*Nice Speech Lady*

## **REASONS TO REFER TO SPEECH PATHOLOGY —**

### **For Physicians, Other Providers, Nurses, PT, OT, RT, and other Allied-Health Professionals**

Speech-language pathology is a field that supports patients in their recovery, along with other members of the multi-disciplinary team. Some patients and families may not demonstrate a full understanding the scope of practice of speech pathologists, and allied health professionals can advocate for a referral to speech pathology, so that patients can receive comprehensive benefits of unique services that speech-language pathologists provide.

The following are the alerts in behaviors or deficits that may justify request a speech-language pathology consult. If an allied health professional observes any of these listed factors, a speech pathology consult may be indicated.

### **SLP LANGUAGE/COMMUNICATION TREATMENT MAY BE INDICATED IF ANY OF THESE FACTORS ARE OBSERVED:**

- Word-finding difficulties, including complaints of difficulties using words to communicate
- Difficulty with understanding speech that is spoken to – simple directions or yes/no questions
- Difficulty with understanding speech that is complex – complex directions or yes/no questions
- Difficulty with naming, or communicating to others in their environment their specific wants/needs
- Unaided hearing loss, family and patient would benefit from limited strategy training to compensate for hearing loss deficits/communication breakdown
- Difficulties with grammar/syntax
- Spelling/writing difficulties due to language deficits
- Difficulties imitating word sequences in sentences
- Would benefit – for any reason – from a picture communication board/system
- Nasal emissions when speaking/resonance difficulties
- Difficulty managing breaths for speaking
- Stuttering, especially new onset due to a recent medical event
- Decline in fluency abilities – worsening of stuttering due to a recent medical event

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**SLP SWALLOWING TREATMENT MAY BE INDICATED IF ANY THESE FACTORS ARE OBSERVED:**

- Difficulties with the oral/mouth phase of swallows (difficulty with drooling, pocketing of food, spitting out of food, not fully chewing food prior to swallowing, choking due to not fully chewing, etc.).
- Difficulties with the throat/laryngeal/pharyngeal phase of swallow, where the following may be observed:
  - Choking,
  - Inconsistent or consistent throat clears during or after swallows,
  - Coughing with PO intake,
  - Difficulty managing secretions,
  - Pain when swallowing,
  - Complaints of food or liquid “getting stuck,” or,
  - Other mouth-level swallowing difficulties.
- Pneumonia diagnosis with suspected dysphagia/swallowing problems
- Recurrent unexplained Pneumonia diagnoses
- Changes in breathing patterns surrounding swallowing
- Frequent upper respiratory infections without explanation
- Recent placement of a feeding tube (difficulty may be with swallowing, difficulty may be with poor PO intake, refusals of PO intake, failure to thrive, s/p intubation, intense time spent in ICU, s/p comatose status, or other factors may have lead to peg-tube surgery.)
- S/p head/neck cancer
- Communication by the patient or family members about fear in choking
- Observed increased anxiety or emotional changes surrounding swallowing
- Tracheostomy – where swallowing would need to be assessed; this is likely before or after the tracheostomy is removed
- Inability or difficulty swallowing pills
- Reflux symptoms where the patient may benefit from lifestyle recommendation education
- Presence of a neurological diagnosis, such as a CVA
- Use of feeding tube long-term (may be indicated to reassess swallowing or other factors which lead to its placement – so to determine if all of the indicated treatments have been attempted)

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- Degenerative neuromuscular problems which may be impacting swallowing (Parkinson's disease, Multiple Sclerosis, Amyotrophic Sclerosis, etc.)
- Unexplained weight loss
- Diet upgrade is being requested by the patient or family
- If a diet downgrade may be indicated for safety (it is observed that the patient is not managing their current food or liquid consistencies safely)

**SLP COGNITIVE-LINGUISTIC Tx MAY BE INDICATED IF ANY OF THESE FACTORS ARE OBSERVED:**

- A memory involvement's severity requires education for the family of the involved patient
- Difficulty with short-term memory or long-term memory
- Difficulty with problem solving/abstract reasoning
- Difficulty with orientation
- Difficulties with sequencing
- Difficulties with inferencing
- Difficulties in follow-through through on safety recommendations and reinforcement from a cognitive perspective is needed for carry-over
- Difficulties with executive functioning/high-level planning skills
- Difficulties with behaviors due to cognitive functioning that impacts the patient's ability to communicate wants/needs

**ARTICULATION TREATMENT MAY BE INDICATED IF ANY OF THESE ARE OBSERVED:**

- Slurred speech (dysarthria)
- Dis-coordinated speech (oral apraxia)
- Difficulties in imitating the sounds in words
- Intelligibility involvement (it is hard for listeners to understand speech of the patient)
- Patient complains of difficulties making sounds

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**VOICE TREATMENT MAY BE INDICATED IF ANY OF THESE ARE OBSERVED:**

- Difficulty in voice quality (sounds raspy)
- Difficulty in appropriate loudness/volume
- Voice patterns that sound unusual, or dis-coordinated, such as spasmodic dysphonia
- Neuromuscular diagnoses which may be impacting communication
- Hoarse voice
- Loss of voice
- Pain when speaking in the laryngeal area
- Tracheostomy – where voice would need to be assessed; this is likely before or after the tracheostomy is removed
- Requires a electrolarynx, Passy-Muir valve, etc., for vocalizing after a laryngeal surgery or tracheostomy placement

**Other factors to consider:**

— In the case of patients who have more than one area of involvement, the evaluation and assessment process for speech pathology can become complicated. For example, if patient exhibits expressive aphasia, it could possibly present a challenge to obtain a clear picture of the patient’s full cognitive-linguistic skills. As well, it may be difficult to assess communication in a cognitive patient due to involved areas.

— If behaviors present themselves, speech pathology’s role may be limited/minimized. For example, if a patient refuses a speech pathology evaluation, the speech pathologist may not be able to make recommendations. As well, if a patient will not consent to speech pathology recommendations, the benefit of the therapy or the outcomes that could occur will be impacted. It will be the role of the speech pathologist in this case to fully document the patient’s communication of refusal of not following recommendations – especially if this impacts safety or could potentially lead to negative medical consequences.

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- The role of ST may be short term, or more involved. The role of ST may only involve an evaluation and recommendations only, may involve an evaluation and limited monitoring in the future or result in a traditional evaluation + treatment visits course.
  
- The role of ST may be longer if the deficit impacts safety, or if the deficit impacts the communication of needs/wants.
  
- If the deficit is more of a long-standing nature — and if treatment is indicated by this speech pathologist — this will be taken into account by the speech-language pathologist, and goals/course of treatment will be modified accordingly.
  
- If the speech pathologist that medical professionals are working with is a “CFY,” this stands for “Clinical Fellowship Year” and they are supervised by a licensed (by the state) and certified (by the American Speech-Language Hearing Association) speech pathologist. The CFY clinician works under the license of the speech pathologist.
  
- Speech pathologists abide by the American Speech-Language-Hearing Association [Code of Ethics](#), and are legally bound to follow license laws specific to the state the services are being provided within.

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