SLT Initial Interview Log

Participant Initials: __ __ __	Trial Number:	P ☐☐☐☐
Date of Birth: MMM / YYYY	Date of Assessment: DD / MMM / YYYY	

Has the participant had an ENT referral prior to therapy? No: ☐ Yes: ☐

Is this interview during the participant's medication "on" phase? No: ☐ Yes: ☐

Abbreviated Mental Test

Carry out the Abbreviated Mental Test (AMT), record the results below. Give a maximum of 30 seconds to answer each question, if the person takes longer mark as incorrect. Ensure you have the person's personal details to check accuracy of the responses.

QUESTION	✔ = correct ✗ = incorrect
1) How old are you?	☐
2) What time is it? (to the nearest hour)	☐
Give the following address for recall at the end of the test: 42 West Street. This should be repeated by the person to ensure it was heard correctly.	
3) What year is it?	☐
4) What is your address?	☐
5) Who are these two people? Show photos of Queen and Pope (both must be correct).	☐
6) What is your date of birth?	☐
7) What year did the Second World War start?	☐
8) What is the name of the present monarch?	☐
9) Count backwards from 20 to 1. This must be exactly correct.	☐
10) Ask for the address given after question 2	☐
TOTAL SCORE	_____

		No	Yes
1) DOES THE PARTICIPANT PERCEIVE PROBLEMS WITH THEIR:	Speech / Voice	☐	☐
	Hearing	☐	☐
	Swallowing	☐	☐
	Other complaints:	☐	☐
	If other, please give details (free text):		

		No	Yes	N/A
2) DOES THE CARER PERCEIVE PROBLEMS WITH THE PARTICIPANT'S:	Speech / Voice	☐	☐	☐
	Hearing	☐	☐	☐
	Swallowing	☐	☐	☐
	Other complaints:	☐	☐	☐
	If other, please give details (free text):			

		No	Yes
3) MEDICATION	Does medication improve speech?	☐	☐
	Does medication improve swallowing?	☐	☐

		No	Yes
4) EXAMINATION OF ORAL CAVITY	Does lack of dentition (own teeth, or dentures / dental plates) negatively impact on speech?	☐	☐

		No	Yes
5) DYSPHAGIA/SWALLOWING Does participant have problems with:	Drooling	☐	☐
	Chewing	☐	☐
	Holding food in their mouth	☐	☐
	Other oral difficulties:	☐	☐
	If other, please give details (free text):		
	Coughing	☐	☐
	Pharyngeal phase	☐	☐
	Other	☐	☐
	If other, please give details (free text):		
	Oesophageal difficulties (inc reflux)	☐	☐

		No	Yes
6) SPEECH	Does your speech affect social activities?	☐	☐
	Does it affect the frequency you socialise?	☐	☐
	Where you socialise?	☐	☐
	Limit your participation in social activities?	☐	☐

		No	Yes
7) HEARING LOSS	Does the participant have a hearing loss that affects his/her conversation?	☐	☐
	Does the participant have hearing aids?	☐	☐
		No	**Yes**
8) Vision	Does the participant use reading glasses?	☐	☐

How far has the participant travelled to this session (miles)? _____

What mode of transport did they use? _____

Will the participant still receive SLT? No ☐ Yes ☐

If no SLT is to be provided, please let us know why not? _____

Form Completed By: _____

Signed: _____ Date: / / (dd/mmm/yyyy)

Form Completion Guidelines:

Please ensure all components of the header of this form are complete prior to sending to the trial office, especially trial number.

Complete the abbreviated mental test.

Please answer/tick all questions on the form.

Please ensure the name of the person completing the form is legible and then please sign and date (with the date the form was completed).

Please ensure you have also completed an SLT Treatment Record Form log as well as this SLT Initial Interview Log at the participants first session.

Take copies of the forms for the participant's records and send the originals to the trial office in the supplied freepost envelopes.

Pictures for Use with AMT