Northeast Health Wangaratta

Outpatient Videofluoroscopy Referral Form

Date of Referral:
Date Referral Received: (Administration Use Only)

Name:	**Gender:** M / F	**Date of Birth:**
Address/Residential Facility:		
Home Phone:	**Mobile/Work:**	

Onset / Diagnosis of dysphagia:
Relevant Medical History (gastro, neuro, respiratory diagnoses, investigations etc):
Cognition (special considerations):
Other Relevant information:

History of Chest Infection: Yes ❑ No ❑ Unknown ❑

ENT involvement: Yes ❑ No ❑ Unknown ❑

Medications: Whole ❑ Crushed ❑ Unknown ❑

Community Speech Pathologist:	
Organisation:	
Postal Address:	**Phone:**

General Practitioner:	
Organisation:	
Postal Address:	**Phone:**

Referrers Name:	
Organisation:	
Postal Address:	**Phone:**

Current Food/Fluid Intake

Food	**Fluid**
❑ Regular fluids ❑ Mildly thickened fluids ❑ Moderately thickened fluids ❑ Limited amounts Level _____ ❑ Nil By Mouth	❑ Regular ❑ Soft ❑ Minced ❑ Puree ❑ Nil By Mouth

Postures Currently Utilized (e.g. chin tuck etc)

Rehabilitative Exercises (e.g. double swallow etc)

Strategies Currently Utilized (e.g. Mendelssohn Manoeuvre etc)

Food/Fluid To Be Trialled

Food	**Fluid**
❑ Regular fluids ❑ Mildly thickened fluids ❑ Moderately thickened fluids	❑ Regular ❑ Soft ❑ Minced ❑ Puree

Postures To Be Trialled (e.g. chin tuck etc)

Rehabilitative Exercises To Be Trialled (e.g. double swallow etc)

Strategies To Be Trialled (e.g. Mendelssohn Manoeuvre etc)

Outcomes sought (e.g. progress with rehabilitative exercises):

A Medical Imaging Request form needs to accompany this referral form. *A Medical Imaging Request form needs to be signed by the client's GP requesting a VFSS procedure.*	SPEECH PATHOLOGY DEPARTMENT COMMUNITY CARE CENTRE PO BOX 386, WANGARATTA, VIC 3676 PHONE: (03) 5722 5555 / FAX: (03) 5722 5419