Northeast Health Wangaratta

Outpatient Videofluoroscopy (VFSS) Referral

Eligibility criteria *(tick all that apply)*:

- ☐ Patient has had a cranial nerve assessment in the past month
- ☐ Patient has had a bedside swallow assessment in the past month
- ☐ Patient is willing to have a modified diet/fluids if results indicate the need
- ☐ Patient is not currently risk feeding
- ☐ Patient is not currently for end-of-life care

If patient does not meet the above criteria: Please contact VFSS Clinician to discuss referral further. Phone: (03) 5722 5555

Referrals:

- This referral form must be completed by a Speech Pathologist who has assessed the patient in the past month (oromotor assessment, bedside swallow assessment, +/cognitive assessment)
- Referral must be accompanied by a Medical Imaging request slip and Barium/ Omnipaque clearance from GP

Please complete all 3 pages of this form and return to: CCIA@nhw.org.au

Date of Referral: _____

OFFICE USE ONLY
Date referral received: Priority:

PATIENT DETAILS

Name: _____

Date of birth: _____

Address: _____

_____

Phone: _____ **Mobile:** _____

Primary language: _____ **Interpreter required:** ☐ Yes ☐ No

Aboriginal or Torres Strait Islander status: _____

Emergency contact name: _____

Emergency contact phone: _____

GP & Clinic: _____

Cultural considerations to be aware of: _____

_____

REFERRER DETAILS

Referrer name: _____

Organisation: _____

Phone: _____

Email: _____

CLINICAL DETAILS

Medical history:

Social history:

Current diet:

Current fluids:

Food and drink dislikes:

****Allergies:** *(e.g coeliac, anaphylaxia, Barium)*

Current strategies used to manage dysphagia: *(i.e. teaspoon, single sips, chin tuck)*

Other details to be aware of:

OROMOTOR ASSESSMENT (Comment on any abnormal features)

CNV:

CNVII:

CNIX/X:

CNXII:

BEDSIDE SWALLOW ASSESSMENT (Comment on any abnormal features)

Consistencies trialed:

Oral phase:

Pharyngeal phase:

Impression: _____

_____

_____

_____

VFSS PROCEDURE

Mobility status: _____

Cognitive and communication status: _____

_____

_____

Patient requires assistance with eating and/or drinking? ☐ Yes ☐ No

If yes – provide details: _____

Diet to trial during VFSS: ☐ Biscuit ☐ Bread ☐ Two fruits
☐ Minced fruit ☐ Puree ☐ Other: _____

Fluid to trial during VFSS: ☐ Thin ☐ Mildly thick ☐ Moderately thick
☐ Extremely thick ☐ Carbonated ☐ Other: _____

Is the patient pregnant? ☐ Yes ☐ No

Transport: *(how patient will attend this appointment)* _____

Patient has asked for final VFSS report to be sent to specialist: ☐ Yes ☐ No
If yes – provide specialist details: _____

_____

CONSENT AND MEDICAL CLEARANCE

Procedure has been discussed with the patient including the risk of radiation exposure:**
☐ Yes ☐ No
***See attached patient handout for procedure details*

Medical clearance for contrast use: *MUST be included in the imaging slip from the GP**

Patient can consume Barium: ☐ Yes ☐ No

Patient can consume Omnipaque: ☐ Yes ☐ No

**See attached template for VFSS contrast clearance request to GP*

Attached for your convenience:

- VFSS patient information handout
- VFSS request for GP template

FOR MORE INFORMATION CONTACT

Speech Pathology
Community Care Centre, Northeast Health Wangaratta, 4-12 Clark Street, Wangaratta

Phone: (03) 5722 5555

Email: speech@nhw.org.au