Beacon Hospital

DEPARTMENT OF SPEECH AND LANGUAGE THERAPY

VIDEOFLUOROSCOPY REFERRAL FORM

Tel: (01) 293 6692 **Fax: (01) 293 6655**

Referral date:	**Patient Name:** **Date of Birth:** **Address:** **Tel No:**
Creditor / order number : (for patients attending from HSE hospital)	

Name of **GP / Consultant:**	Address of **GP / Consultant:**	Tel No. of **GP / Consultant:**
Name of referring **SLT:**	Address of referring **SLT:**	Tel No. of referring **SLT:**

CHECKLIST TO COMPLETE PRIOR TO PROCEEDING WITH REFERRAL

- Is the patient medically stable / well enough to tolerate travel and investigation? Yes □ No □
- Is the patient wheelchair bound? Yes □ No □
- Does the patient have good sitting balance and head posture? Yes □ No □

Please note there is no access to hoists in the fluoroscopy suite. Patients cannot be transferred from a bed / stretcher to chair, therefore patients must attend the appointment in the appropriate seating in an upright position for swallowing.

* PLEASE NOTE *

Referral cannot be accepted without a medical referral (see final section of form)

Where creditors / order number are being provided as payment, appointments cannot be scheduled until this is received.

REFERRAL INFORMATION

Summary of Medical History Including medical conditions & please comment on respiratory status i.e. frequency of chest infections	**Reason for referral / clinical question**
Current nutrition & hydration (oral/NG/PEG)? Which food / drink consistencies are currently being taken?	**Any other relevant information?**

REFERRING DOCTOR'S NAME:	**REFERRING DOCTOR'S ADDRESS/BASE:**
REFERRING DR'S SIGNATURE:	

Please stick addressograph here