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:** **Next of Kin:**
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:**
Please indicate who you would like additional reports to be sent to:		
Full Name & Address	Full Name & Address	Has the patient given **consent** for additional report(s) to be sent? Yes □ No □

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 □
- Any allergies (food/fluid/other) Yes □ No No □

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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.

Patients should arrive in good time for their appointment. Please contact SLT on 0870501931 if there will be a delay in arriving. Failure to arrive on time may result in the patient missing their slot.

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

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

Please stick addressograph here