Please stick addressograph label here containing all three patient identifiers, Name, Date of Birth and MRN

DEPARTMENT OF SPEECH AND LANGUAGE THERAPY

FIBREOPTIC ENDOSCOPIC EVALUALTION OF SWALLOW (FEES) REFERRAL FORM

Post: Adult Speech and Language Therapy, Physiotherapy Department, Suite 20, Beacon Hospital, Dublin 18

Email: SpeechTherapy@beaconhospital.ie Tel: (01) 293 6692 Fax: (01) 293 6655

Please note:

- Referrals cannot be accepted if the referral form is incomplete or if there is no signed medical consent.
- Where purchase order numbers are being provided as payment, appointments cannot be scheduled until this is received.
- There is no access to hoists in the endoscopy suite. Patients cannot be transferred from a bed/ stretcher so must be independent in transfers or attend in the appropriate seating in an upright position to swallow.
- Patients should arrive in good time for their appointment. Please contact SLT on 0870501931 or 0871843809 if there will be a delay. Failure to arrive on time may result in the patient missing their slot.

Beacon Hospital

Please stick addressograph label here containing all three patient identifiers, Name, Date of Birth and MRN

FIBREOPTIC ENDOSCOPIC EVALUATION OF SWALLOWING – MEDICAL CONSENT

Patient name:	
Patient DOB:	
Patient address:	
Patient telephone:	
Referring doctor:	
Contact details:	

Checklist of contraindications for FEES (tick as appropriate)

Skull base facture/surgery within last 6 weeks	Yes □	No □
Facial fracture/surgery within last 6 weeks	Yes □	No □
Severe movement disorder/agitation	Yes □	No □
Sino nasal or anterior skull base tumour	Yes □	No □
Life threatening epistaxis within last 6 weeks or history of severe epistaxis	Yes □	No □
Trauma to nasal cavity due to surgery or injury within last 6 weeks	Yes □	No □
Hereditary haemorrhagic telangiectasia	Yes □	No □
Choanal	Yes □	No □
Cardiac instability or vasovagal history	Yes □	No □

Extra consideration may be required for certain conditions. Please call us to discuss if your patient has the following, as they may require ENT consult prior to SLT led FEES:

- Nasopharyngeal stenosis
- Craniofacial abnormalities
- Significant airway limitations (large volume disease/cancer)
- Significant bleeding risks e.g. high amounts of anticoagulants

Comments/ requests:

By signing below, you have provided medical consent for this patient to participate in a Fibreoptic Endoscopic Evaluation of Swallowing procedure, completed by the Speech and Language Therapy team at Beacon Hospital.

Signature:

Beacon Hospital

Please stick addressograph label here containing all three patient identifiers, Name, Date of Birth and MRN

FIBREOPTIC ENDOSCOPIC EVALUATION OF SWALLOWING – Speech and Language Therapy Handover

Patient name:		**MRN:**	
Patient DOB & age:		**Allergies/ infections:**	
Patient address:			
Patient telephone:			
Referring SLT name:		**Telephone:**	
Email:			
PO number:			
Invoice address:			
Medical and social history:			
Clinician/ family member/carer to attend?	*Y/N – contact details*		
Reason for FEES: *What question are we trying to answer that cannot be answered at bedside?*			
Current function/ recommendations: *Swallowing/ communication/ cognition*			
SLT hypothesis of dysphagia status:			
Consistencies/ compensatory strategies to trial:			