Instrumental Assessment Referral Form

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| Patient details |  |

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| Name:Address:E-mail Address:ACC INFORMARTION (if applicable)ACC Number: ACC Purchase Order Number:  | DOB:Contact Phone: Date of Injury: **ACC Case Manager:** | NHI number:Gender: Male / Female / DiverseACC E-mail address: |

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| Referrer details |  |

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| --- | --- |
| Name:Phone: | Position:E-mail: |
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Address:

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| Examination Requested (tick one): |  |

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| * **Videofluoroscopic Swallowing Study (VFSS)**
* **Videofluoroscopic Swallowing Study +/- manometry**
* **Flexible Endoscopic Swallowing Evaluation (FEES)**
* **Instrumental exam as deemed necessary**
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| Clinical Information: |  |

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| **Presenting complaint:** |
| **Question to be answered:**  |
| **Relevant medical history: (including etiology; recent procedures; recent investigations; dates)*****Please attach relevant clinical letters or investigation reports.*** |
| **Additional Requirements:*** **Wheelchair**
* **Supplemental O2**
* **Contact/Isolation Precaution**
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| **Referrer signature: Date:** |
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