Rosebud Swallowing Clinics

Paediatric Instrumental Assessment Referral Form

Patient details

Name of child:
DOB:
NHI number:
Caregiver name:
Contact Phone:
Child's gender: Male / Female / Diverse
Address:
E-mail Address:
GP Details:

ACC INFORMARTION (if applicable)

ACC Number:
Date of Injury:
ACC E-mail address:
ACC Purchase Order Number:
ACC Case Manager:

GP Name:
GP Contact (email preferred):

Referrer details

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

If referrer is not a medical doctor, have you obtained specialist medical consent prior to sending referral? (please attach correspondence or indicate verbal consent and from whom)

- ☐ Written consent (attached)
- ☐ Verbal consent

Contact details of the healthcare professional (email or phone): _____

- ☐ Permission to communicate with the above contact

Examination Requested (tick one):

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

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Clinical Information:

Presenting concern:

Question to be answered:

Relevant medical and developmental history: (including etiology; recent procedures; recent investigations; dates)

Please attach relevant clinical letters or investigation reports.

Additional Requirements (wheelchair, supplemental O2):

Please note: This is an outpatient clinic with swallowing specialists (SLTs). No medical specialists are on-site.

Referrer signature: **Date:**