Rehabilitation Clinics

Instrumental Assessment Referral Form

Patient details

Name: **DOB:** **NHI number:**

Address: **Contact Phone:** **Gender: Male / Female / Diverse**

E-mail Address:

ACC INFORMARTION (if applicable)

ACC Number: **Date of Injury:**

ACC Purchase Order Number: **ACC Case Manager:** **ACC E-mail address:**

GP Name:

GP contact (email preferred):

Referrer details

Name: Position: Address:

Phone: E-mail:

Examination Requested (tick one or more):

Doctor consent for procedure obtained: ☐

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

Clinical Information:

Presenting complaint:

Question to be answered:

Leinster Chambers, Level One, 249 Papanui Road, Christchurch 8014 Ph. +64 3 3691326 Fiona.bellett@canterbury.ac.nz

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

Please attach relevant clinical letters or investigation reports.

Additional Requirements:

- ☐ **Wheelchair**
- ☐ **Supplemental O2**
- ☐ **Suctioning**
- ☐ **Contact/Isolation Precaution**

Please note: This is an outpatient clinic with swallowing specialists (SLTs). There is no medical specialist on-site.

Referrer signature: **Date:**