**PAEDIATRIC VIDEOFLUOROSCOPY SWALLOW STUDY REFERRAL FORM**

**Paediatric speech and language therapy service**

Videofluoroscopy swallow study referrals

Department of Dietetics

Chelsea and Westminster Hospital

369 Fulham Road

London, SW10 9NH

**T:** 020 3315 6570

**F:** 020 3315 8077

Date of referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient details:

Name Dob

NHS no Age

Address Tel

GP (Full name and address)

Referrer name and title

Referrer contact details (Address, telephone, email)

Medical diagnosis:

Professionals involved: (Please provide full name and address)

Mobility:

Walking: ( ) Yes ( ) No Wheelchair (specify):

Reasons for referral:

**Please include detailed clinical feeding assessment report – no appointments will be booked without**

History: (please provide brief description where relevant)

Feeding history (Provide brief history of feeding since birth):

Other relevant information:

Results of previous objective swallow assessments (VFSS, FEES)

Hospitalisations

Surgical procedures

Medication

Seizures

Social concerns

Transport required: ( ) Yes - Please specify type: ( ) No

Parental/carer consent obtained for referral and distribution of report to relevant professionals: ( ) Yes ( ) No

|  |
| --- |
| Concerns regarding development: ( ) Yes - Specify  ( ) No |

|  |
| --- |
| Seating requirements:  Infection status:  Additional comments |

Name:

Contact information (including Telephone number and email address)

**IMPORTANT**

**Local SALT referring for videofluoroscopy swallow study is expected to attend the study. Please note that we do not have access to interpreters except through language line.**

**Address for referrals:**

**Analou.sugar@nhs.net**

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