Western Health

Speech Pathology Department
Outpatient Dysphagia Clinic Referral Form

☐ **Sunshine Hospital** ☐
☐ ☐

Name: ______________________
Date of birth: ______________________
Address: ______________________
PATIENT IDENTIFICATION LABEL
Western Health UR (if known): __________

Please fax referral form to: (03) 8345 6529
For enquiries, please contact Speech Pathology on: (03) 8345 1559

Date of referral: ______________________

Patient details:

Primary Language: ______________________ **Interpreter Required**: Yes ☐ No ☐

Primary contact regarding appointment:

Name: ______________________ Relationship: ______________________

Phone: ______________________

Past medical history: ______________________

Other relevant information (eg. social history, communication status, mobility, seating support) if applicable: ______________________

Referral details:

Referrer:

Name: ______________________ Position: ______________________

Hospital/agency/clinic: ______________________ Phone/pager: ______________________

Reason for referral/intervention required (including current swallow function, diet/fluids, nutritional status, expected outcome): (*or see attached discharge summary/report* ☐)

Previous Instrumental Swallowing Assessment/s:

☐ VFSS ☐ FEES ☐ Other ______________ ☐ Report attached

Summary of findings: ______________________

Videofluoroscopic Swallowing Study (VFSS) Approval

All referrals to the Dysphagia Clinic require *accompanying written approval* from a Medical Officer for the patient to undergo a VFSS. PLEASE COMPLETE ONE OF THE FOLLOWING OPTIONS.

☐ A Medical Imaging Request form has been completed by a Medical Officer and attached.

OR

☐ A Medical Officer has completed the below form:

Please complete a Videofluoroscopic Swallowing Study to investigate swallowing function for the above patient.

Signed: ______________________ **Contact details:** ______________________

Print Name: ______________________

Provider number: ______________________

To print copies of this referral form, go to: http://www.westernhealth.org.au/Services/Speech_Pathology/

Trial Form

Outpatient Dysphagia Clinic Referral Form

AH 640

Western Health

Form Title Line 1

Form Title Line 2

☐ Western Hospital ☐ Williamstown Hospital
☐ Sunshine Hospital ☐ Sunbury Day Hospital

PATIENT IDENTIFICATION LABEL