Paediatric Instrumental Assessment Referral Form

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| Patient details |  |

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| Name of child:  Caregiver name:  Address:  E-mail Address:  ACC INFORMARTION (if applicable)  ACC Number:  ACC Purchase Order Number:  GP Name:  GP Contact (email preferred): | DOB:  Contact Phone:  Date of Injury:  **ACC Case Manager:** | NHI number:  Child’s gender: Male / Female / Diverse  GP Details:  ACC E-mail address: |

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| Referrer details |  |

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

Address:

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

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| |  |  |  | | --- | --- | --- | | Examination Requested (tick one): |  |  |  |  | | --- | | * **Videofluoroscopic Swallowing Study (VFSS)** * **Videofluoroscopic Swallowing Study +/- manometry** * **Flexible Endoscopic Swallowing Evaluation (FEES)** * **Instrumental exam as deemed necessary** | | |  |  | | --- | --- | | 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:** | | |  | |  | | | |