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 / DiverseGP Details:ACC E-mail address: |

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| Referrer details |  |

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

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

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| **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:** |
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