Health
Northern Sydney
Local Health District

Clinic Coordinator Use Only
Date received: ________________________
Triage category: 1 month
3 months
Appointment booked (Date): _____________
Other note:
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____

RNSH Voice and Swallow Clinic Referral Form

Patient/Referral Information		
Name:_____________________________ Address:____________________________ __________________________________ MRN__________________________ D.O.B:_____________ Age:___________ Interpreter Y/N: ____________________	Treating SP:_____________________ Contact: Ph:____________pg______ Treating Team:__________________ Contact:_______________________ Treating Clinician attending Y/N	☐ Consent for Nasendoscopy/FEES obtained from client ☐ Client educated about Nasendoscopy/FEES procedure

Background Medical Information ***(Include respiratory support required, mobility and level of assistance required, if applicable. Consider the patient's cognitive status and whether they could tolerate instrumental assessment.)***

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Rationale for Referral

☐ Voice Assessment ____
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☐ FEES *(including strategies to trial)* ____
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Previous/Current Speech Pathology Intervention ***(Attach relevant reports)***

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Current diet/fluids and nutritional status:____
Strategies/techniques trialed:____
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