

**Paediatric Videofluoroscopic Swallow Study (VFSS) Referral form**

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| **SECTION 1: Patient details** |
| **Child’s first name** |  |
| **Child’s surname** |  |
| **D.O.B** |  |
| **NHS no.**  |  |
| **Address** |  |
| **Parent or Guardian name** |  |
| **Parental responsibility (name and relationship)** |  |
| **Home/Mobile Tel no.** |  |
| **Interpreter required?** |  No  Yes – the language required is |
| **Safeguarding** | Are there any safeguarding concerns?  No  Yes- please give detailsIs the child on a Child Protection Plan or a Child in Need?   No  Yes- please give details including social worker contact detailsIs the child looked after (i.e. under the care of the Local Authority)?  No  Yes- please give details including social worker contact details |
| **GP Details** |  |
| **Has the child previously had a VFSS?** |  No Yes – date: Name of hospital:*Please attach copy of report* |

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| **SECTION 2: Clinical details** |
| **Main medical diagnosis/es** |   |
| **Relevant medical/surgical history*****This should include all gastroenterology, cardiac, renal, metabolic, neurological or other history. Please highlight any specific cardiac, renal, metabolic/ketogenic conditions as an alternative thickening agent or barium contrast may need to considered in advance***  |  |
| **Medications *Please include all relevant medications including gastroesophageal reflux medications***  |  No Yes – *please give details:*  |
| **Allergies and sensitivities *Please include details as an alternative thickening agent or barium contrast may need to considered in advance*** |  No Yes – *please give details:*  |
| **Infection status** | Does the child have any known infections? No Yes – *please give details:*  |
| **Respiratory History*****e.g. number of chest infections (lower respiratory tract), admissions to hospital.*** |  |
| **Brief Feeding History *please outline brief feeding history e.g weaning, previous trials of thickener etc*** |  |
| **Tracheostomy?****Ventilation?** |  No Yes – type and size of tracheostomy tube: Is a speaking valve used?  No  Yes  No Yes – *please give details:*   |
| **Oxygen dependency?** |  No Yes – *please give details:* |
| **Alternative feeding?**  |  No Yes – NG / PEG / PEGJ / TPN / Other |
| **How much does the child take orally?** | Approximate amount of fluid a day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Approximate amount of food a day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Is weight or nutrition of concern?**  |  No Yes**Please specify centiles**Weight: Height/length:  |
| **Physical ability & positioning*****Please tick the appropriate seating for the patient. Please note that head rests may need to be removed for purpose of the study as it may impact on the quality of the images.***  |  Tumbleform chair Normal chair Own chair  headrest Can the head rest be removed/changed if required?  Yes  NoComments on positioning:    |
| **Communication*****Please provide a summary about the child’s communication skills e.g. comprehension level, speech intelligibility, expressive language skills, voice quality and any recent changes to this*** |  |

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| **Summary of eating & drinking assessment/s***Please attach all recent relevant reports including previous VFSS studies* |
| **Date of last assessment** |  |
| **Feeding abilities** |  Independent  Requires assistance  Fed by Carer |
| **Child’s ability to co-operate** |  Aversive  Often refuses  Rarely refuses  Other  Social communication disorder  Fear of hospital  |
| **Saliva management *e.g. at rest, on activity, during and after eating & drinking. Any medical or behavioural management.*** |  |
| **List fluid & food consistencies assessed** | Fluids | Food |
| **Oral phase presentation*****e.g. consistencies observed, utensil used (teat size, cup), control, transfer, mastication.***  |  |  |
| **Pharyngeal phase presentation *e.g. timing of swallow, efficiency of swallow, signs of risk, no. of swallows needed*** |  |  |
| **Intervention and strategies trialled to date and the success of these?*****e.g. positioning, pacing, environment, equipment, modification of textures/fluids*** |  |  |
| **Current feeding/eating & drinking textures and recommendations *– please include approximate volumes of oral intake per feed/day*** |  |  |
| **Current feeding eating/drinking concerns *e.g. SLT/parent/school. Include any concerns with compliance from any parties*** |  |
| **Objectives of VFSS/Questions to be answered** ***Please state clearly, especially if not clear from assessment findings e.g. suspicion of silent aspiration due to unexplained respiratory infections, suspicion of structural anomaly. Consistencies to be assessed – bear in mind time limiting nature of procedure.*** |  |

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| **SECTION 3: Consent and signatures** |
| **Has the referring clinician gained verbal consent & discussed purpose of this VFSS referral with the child/parents?** |  Yes  No - please explain why |
| **Has the referring clinical discussed possible outcomes of VFSS? *E.g. changes to feeding techniques, and if appropriate, dialogue about possible need for supplementation or alternative feeding methods with child/parent?*** |  Yes - please give details No - please explain why |

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| **Other professionals who should receive copies of the report:***Parent/guardians and GP will routinely receive a copy* |
| Name & Designation | Address |
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**Speech & Language Therapy contact details.**

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| --- | --- | --- | --- |
| **Name** |  | **Telephone** |  |
| **Address** |  |
| **Designation** |  |
| **Date** |  | **Email**  |  |

**If you are unable to attend the appointment please nominate a colleague who can attend or is available to follow up recommendations on the day of the appointment**

**Nominated Speech & Language Therapy contact details**

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| --- | --- | --- | --- |
| **Name** |  | **Telephone** |  |
| **Address** |  |
| **Designation** |  |
| **Date** |  | **Email**  |  |

**Please note referrals will only be accepted with medical consent.**

**Please confirm that this videofluorscopy swallow study request been discussed and agreed with the infant/child’s leading medical consultant or GP?**

 Yes

**Medical Referrer contact details**

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| **Name** |  | **Telephone** |  |
| **Address** |  |
| **Designation & GMC number. *Please notes that the GMC number is required in line with the new IRMER regulations*** |  |
| **Date** |  | **Email**  |  |

**Please complete and return to:**

Lesley Baker, Clinical Specialist Speech & Language Therapist, Floor 4, Becket House, Evelina London

St Thomas’ Hospital, Westminster Bridge Rd, London SE1 7EH or email completed form to lesley.baker5@nhs.net

**Contact number:** 020 7188 3992

**Please ensure that all sections of the referral form are completed as incomplete forms may be rejected.**

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| **Additional information**Findings from the assessment and recommendations will not be discussed with the parents/carers at the time of the assessment. Verbal feedback will be provided to the referring clinician on the day of the assessment. If the referring clinician is not available, a written handover will be emailed. A formal report will be completed following this and distributed to the relevant professionals as listed above including the GP and the parents/carers.  |

**----------------------------------------------------------For office use only-----------------------------------------------------------------**

**Referral accepted:**

 No Reason why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes

**Justified & authorised by (signature)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Name \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HCPC No**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_