

**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 and contact details****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 if not performed at ELCH* |
| **Why are you referring the child for a VFSS?** ***Clinical question/ concerns*** |  |
| **Is this child known to an Evelina London Consultant?**  | Name:Team:  |

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| **Please ensure that you have discussed this referral with the family prior to referring for VFSS** (an appointment will not be offered if this section is not complete) | *Please tick to show discussed*  |
| VFSS involves the use of X-rays. Are the parents aware of this and have they consented?  | **​​☐​**  |
| Have you discussed with the family / child possible outcomes of VFSS and/ or alternative methods of feeding if needed?  | **​​☐​**  |
| Is the child having a minimum of 30mls orally (food or fluid equivalent)?   | **​​ ☐​**  |
| Has the VFSS request been discussed and agreed with the leading medical consultant or GP?  | **☐** |

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| **SECTION 2: Clinical details** |
| **Main medical diagnosis/es****Relevant medical/ surgery history*****This should include all respiratory, gastroenterology, cardiac, renal, metabolic, neurological or other history.******Include details re: trache, O2, infections*** |   |
| **Medications** ***Please include all relevant medications including gastroesophageal reflux medications***  |  |
| **Allergies and sensitivities** ***Please include details as an alternative thickening agent or barium contrast may need to considered in advance*** |  |
| **Brief Feeding History** ***Include current feeding plan/ method, findings and recommendations/ strategies from most recent clinical feeding assessment (attach report if available), self-feeding ability, specialist equipment etc*** |  |
| **Positioning & seating for mealtimes*****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.***  |    |
| **What consistencies is the child currently taking?** |  |
| **What food/ drink (DDSI levels) would you like assessed in the study?** |  |
| **Child’s level of communication*****e.g. comprehension level, speech intelligibility, expressive language skills, voice quality and any recent changes to this*** |  |

**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.**

**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**  |  |

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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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**Please complete and return to:**

Laura Baird, Clinical Specialist Speech & Language Therapist, Floor 4, Becket House, Evelina London Children’s Hospital, Westminster Bridge Rd, London SE1 7EH or email completed form to: laura.baird2@nhs.net

**Contact number:** 020 7188 3992

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