ABI COMMUNITY REHABILITATION

NDIS Videofluoroscopy Swallow Study (VFSS) Referral

REFERRAL DETAILS:

Date of Referral: _____ **Referring organisation/clinician:** _____

Address: _____

Relationship to client: _____ **Telephone:** _____ **Email:** _____

Consent for referral: I consent to VFSS and sharing results with GP and primary treating SP

☐ Yes ☐ No

Name: _____ **Signature:** _____ **Date:** _____

CLIENT DETAILS:

Family Name: _____ **First/Preferred name:** _____

D.O.B: _____ **Sex:** _____

Address: _____ **Postcode:** _____

Telephone: _____ **Email:** _____

Medicare Number: _____ **Ref:** _____ **Expiry:** _____

NDIS Number: _____

NDIS Support Coordinator: _____

NDIS Plan Dates: _____

Plan Manager: _____ **Email:** _____

Plan Nominee details (if applicable): _____

Client has 5 hours of speech pathology funding available this current quarter for VFSS?

☐ Yes ☐ No

Primary contact/ NOK: _____

Name: _____ **Relationship:** _____ **Telephone:** _____

Interpreter required ☐ Yes ☐ No **Language:** _____

Aboriginal or Torres Strait Islander: _____

ACQUIRED BRAIN INJURY & RELEVANT MEDICAL INFORMATION

Primary diagnoses and date of injury:

_____

_____

Reason for referral:
☐ Concerns regarding safety of current fluids/diet
☐ Education to support follow through of recommendations
☐ Texture progression ☐ Clinician needing further support for intervention planning
☐ Frequent choking / coughing / gagging during meals
☐ Frequent coughing / wet voice / watery eyes with fluids
☐ Chronic respiratory problems including chest infections/ pneumonia
☐ Trouble handling saliva
☐ Comfort / risk feeding ☐ Other:

Previous VFSS conducted? ☐ No ☐ Yes **Location completed:** _____
Please attach VFSS report if conducted outside Alfred Health.

Respiratory History (i.e. number of chest infections, lower respiratory tract, hospital admissions):
☐No concerns ☐ History of chest issues, but none in last 6 months
☐ > 3 chest infections in past 12 months ☐ Respiratory condition diagnosed:
☐ Hospitalisations with aspiration pneumonia, dates: _____

Risk of malnutrition/dehydration?
MUST score if known
☐ None ☐ Reduced fluid intake +/- constipation ☐ Weight loss
☐ Sudden changes / presenting with signs of dehydration or significantly reduced intake*
** please liaise with GP re: urgent medical attention if required*

Physical ability/positioning:
☐ Walking ☐ Independent with transfers ☐ Non ambulating

Communication & Participation:
Expressive: ☐ Requires support/AAC to communicate ☐ Using words to communicate
Receptive language: ☐ Requires visuals supports ☐ Follows simple instructions ☐ Functional comprehension

Other comments (e.g. behaviour concerns):

Cultural or religion food preferences and/or Allergies: _____

SUMMARY OF EATING AND DRINKING ABILITIES:

Feeding ability: ☐ Independent ☐ Requires assistance ☐ Fully dependent on feeder

Co-operation/interest: ☒ Always refuses ☐ Often refuses ☐ Rarely refuses

Seating: ☐ No concerns ☐ Specialised seating ☐ Requires head support with seating

Saliva management: ☐ Nil concerns ☐ Drooling (please circle) - Mild, Moderate, Severe
☐ Poor secretion management (e.g. coughing on saliva at night, requires suctioning)

Oromotor examination: _____

Method of feeding: ☐ Oral ☐ Oral + enteral (NGT / PEG) ☐ Enteral with minimal oral intake /NBM

Fluids: ☐ Thin fluids, no concerns ☐ Coughing with thin fluids, have not trialled thickened fluids
☐ Thickened fluids, no signs of aspiration IDDSI: 1 2 3
☐ Thickened fluids, overt signs of aspiration IDDSI: 1 2 3

Overt clinical signs of aspiration with fluids?
☐ None ☐ Occasional coughing < 1 daily ☐ Frequent coughing > 2 – 4 times daily ☐ Wet voice

Diet: ☐ IDDS 4- smooth puree ☐ IDDSI 5- minced & moist ☐ IDDSI 6- soft & bited sized
☐ IDDSI 7 easy to chew ☐ IDDSI 7 regular diet

Concerns regarding tolerance of diet?
☐ None ☐ noisy breathing with solids ☐ Wet voice ☐ Slow oral transit
☐ Occasional coughing/choking < 1 daily ☐ Frequent coughing/choking > 2 – 4 times daily

Mealtime duration: ☐ Mealtimes <30 minutes ☐ Mealtimes 30-60minutes ☐ Fatigue during mealtimes

Other relevant information /comments:
_____

_____

Requested fluids, food & strategies to assess in VFSS:

Fluid	Food	Strategies	Equipment

Speech Pathologist: _____ **Organisation:** _____

Contact information (phone number, fax, email): _____

Copies of the VFSS report to be sent to: _____

Medical referral attached: ☐ Yes ☐ No
If not, please obtain written medical referral to support VFSS referral

NDIS Mealtime Assessment attached: ☐ Yes ☐ No

Please return completed referral forms via e-mail:
abicommunity&tls@alfred.org.au | Subject "ATTN: VFSS Referral"