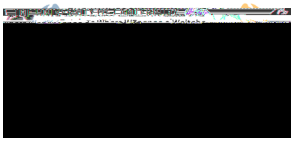

Patient details

Name of child:

Caregiver name:

Address:

E

Referrer details

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

Examination Requested (tick one):

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

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