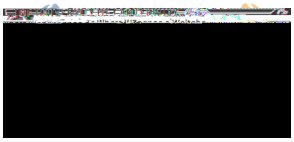

**Name:** **DOB:** **NHI number:**

**Address:** **Contact Phone:** **Gender: Male / Female / Diverse**

**E-mail Address:**

## ACC INFORMARTION (if applicable)

**ACC Number:** **Date of Injury:**

**ACC Purchase Order Number:** **ACC Case Manager:** **ACC E-mail address:**

**GP Name:**

**GP contact (email preferred):**

- ☐ **Videofluoroscopic Swallowing Study (VFSS)**
- ☐ **Videofluoroscopic Swallowing Study +/- low resolution pharyngeal manometry**
- ☐

**Presenting complaint:**

**Question to be answered:**

**Relevant medical history: (including etiology; recent procedures; recent investigations; dates)**

***Please attach relevant clinical letters or investigation reports.***

**Additional Requirements:**

- ☐ **Wheelchair**
- ☐ **Supplemental O2**
- ☐ **Suctioning**
- ☐ **Contact/Isolation Precaution**

*Please note: This is an outpatient clinic with swallowing specialists (SLTs). There is no medical specialist on-site.*

**Referrer signature:** **Date:**