Videofluoroscopy Information & Preparation Form

This form must be filled out by the child's local Speech and Language Therapist (SLT) & returned to the SLT Department, CHI at Temple St, Dublin 1 as soon as possible. The child's priority rating for videofluoroscopy will include information received from this form. Local SLT attendance is strongly encouraged at videofluoroscopy. Please turn over to appendix overleaf for additional space.

Child's Name:		**DOB & Current Age:**	
Parents/Guardians Names		**Contact numbers:**	
Reason for Requesting Videofluoroscopy (VFSS):			
Who referred for VFSS?	Consultant: _____	SLT: _____	
Local Services Involved: (tick all applicable & provide service name)	Primary Care: ☐	Children's Disability Network Team: ☐	Other: ☐
Relevant Medical History:			
Current Feeding Recommendations:	**Fluids:** IDDSI Level 0 ☐ IDDSI Level 1 ☐ IDDSI Level 2 ☐ IDDSI Level 3 ☐ Thickener used (if applicable): _____ **Food:** IDDSI Level 4 Puree ☐ IDDSI Level 5 Minced & Moist ☐ IDDSI Level 6 Soft & Bite Sized ☐ IDDSI Level 7 Regular ☐ IDDSI Level 7 Easy Chew ☐ Transitional Foods ☐		
Results and Date of Most Recent Swallowing Assessment:			
Interventions Trialled & Outcomes: (tick all applicable)	Swallow rehabilitation: ☐ _____ Utensils/Equipment: ☐ _____ Positioning: ☐ _____ Pacing: ☐ _____ Thickener: ☐ _____ Other: ☐ _____		
Please provide information on what you wish the VFSS team to examine & how. Please order in terms of priority starting with consistency of most concern. Include utensils, positioning to be used & any other intervention	1. Seating _____ 2. Utensils inc bottles/cup to use _____ 3. IDDSI consistencies to be trialled in order of priority_____ _____ 4. Other relevant info (e.g. sensory issues)_____		
Has the child practised with all of these consistencies prior to VFSS? A consistency **cannot** be trialled for the first time at VFSS unless it's a thicker liquid **OR**			Yes ☐ No ☐
Has the local SLT discussed with the child's consultant whether a trial of a new consistency could be started by local SLT 1-2 weeks prior to the child's VFSS?			Yes ☐ No ☐
Other Relevant Information e.g. social hx, enteral feeding discussion			
SLT Availability to Attend VFSS Please indicate any Thur mornings in next 6 months SLT will be unavailable	Yes ☐ No ☐ Unavailable Dates: _____		

Form Completed By: Name: _____ CORU No: _____

Signature: _____ Date: _____

Appendix
Please provide any additional information that will be useful to the videofluoroscopy team

Form Completed By: Name: _____ CORU No: _____

Signature: _____ Date: _____