Sláinte Leanaí Éireann
CHI
Children's Health Ireland

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 in CHI 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.

Received by:
Date:
MRN:

Child's Name:		**DOB & Current Age:**	
Parents/Guardians Names		**Contact numbers:**	
Reason for Requesting Videofluoroscopy (VFSS):			
Who referred for VFSS?	Consultant: _____	SLT: _____	
Consent for referral:	Has the referral been discussed and consented to by the child and family? Yes ☐ No ☐		
Local SLT contact details			
Local Services Involved: (tick all applicable & provide service name)	Primary Care: ☐	Children's Disability Network Team: ☐	Other: ☐
	CRC Feeding Team: ☐	CAMHS: ☐	
Relevant Medical History:			
Communication Status *Please include any relevant information for supporting the child during the assessment process*			
Relevant Feeding History:			
Current Feeding Recommendations:	**PO Status:** Oral ☐ Mixed Oral/Enteral ☐ Enteral ☐ Type of Enteral Feeding (if applicable): _____ **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: ☐ _____ Alterations to Taste/Temperature: ☐ _____ Other: ☐ _____		

Form Completed By: Name: _____ CORU No: _____
Signature: _____ Date: _____

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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. Fatigue/Endurance/Timing of screening considerations _____ 5. Other relevant info (e.g. sensory issues)_____
Has the child practiced 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, eating and drinking with acknowledge risk (EDAR) discussion, other personal or environmental considerations	
SLT Availability to Attend VFSS Local SLT attendance is always encouraged & beneficial.	Yes ☐ No ☐ Other _____ *Please note appointments are sent by Radiology rather than SLT.* ***Please link with the child's parents regarding appointment date/time***

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

Additional relevant reports can be sent in with this form

Form Completed By: Name: _____ CORU No: _____
Signature: _____ Date: _____