SCREENING – PATIENT INFORMATION (TO BE COMPLETED BY PATIENT / CARER /ANYONE WHO KNOWS THE ACCURATE INFORMATION)

PATIENT/CLIENT NAME:	**CARERS NAME:**	**DATE OF BIRTH:**

PROFESSION		**REFERRED BY** (CONSULTANT NAME)	
ADDRESS		ADDRESS	
POST CODE		POST CODE	
TELEPHONE	HOME	TELEPHONE	
	MOBILE	HOW DID YOU HEAR ABOUT THIS TREATMENT – PLEASE SPECIFY	
	WORK		

GP NAME	**PREVIOUS SPEECH LANGUAGE THERAPIST** YES/NO
ADDRESS	NAME
	ADDRESS
POST CODE	POST CODE
TELEPHONE	TELEPHONE
OTHER PROFESSIONALS INVOLVED	

MEDICAL DETAILS	
DETAILS WITH DATES AND BRIEF RESULT ON VIDEO FLUOROSCOPY SWALLOW STUDY (VFSS) AND / OR FIBRE OPTIC ENDOSCOPE OESOPHAGEAL SWALLOW STUDY (FEES**)**	
HEARING / VISION / MOBILITY	
MEDICAL DIAGNOSIS:	
RELEVANT ASSOCIATED CONDITIONS: DIABETES / HEART / CHEST / OTHER	
DATE OF ONSET:	
TONGUE STATUS – INDICATE SPEED OF MOVEMENT (F=FAST………, A=AVERAGE……, S=SLOW…………..) INDICATE RANGE (DISTANCE) OF MOVEMENT (M=MORE…….., L=LESS…….., N= NO MOVEMENT……….) INDICATE DIRECTION OF MOVEMENT TO RIGHT …., LEFT….., UP….., DOWN….OUT, …..IN	
LIPS STATUS – INDICATE ABILITY OF LIPS SPREAD….,POUT….,KISS….,OPEN……,CLOSE…..	
SALIVA CONTROL PRESENT / ABSENT	
MODE OF FEED – FOOD AND LIQUID / AMOUNT – VOLUME – QUANTITY / PER DAY	
COMMUNICATIONS – UNDERSTANDING / EXPRESSION / PREVIOUS LANGUAGE / LITERACY ABILITIES	
ADMISSION / HOSPITALISATION WITH DATES AND EVENTS	
INVESTIGATIONS WITH DATES IN BRIEF	

Medication	Dose	To Treat

PATIENT/CARER'S EXPECTATIONS

TO BE COMPLETED BY THE CONSULTANT DURING INITIAL CONSULTATION

ANY OTHER INFORMATION

DATE: **TIME:**