Video Fluoroscopic Swallow Study Intake Form (SLP)

Official Therapy Provider for Penn Medicine

Patient Name _____ Referring Physician _____

Anticipated Date of Study _____ Current Diet _____

Primary Speech Pathologist (SLP) Name _____

Please Circle One: Home Care / Outpatient / Skilled Nursing / Acute Rehabilitation Facility

Primary SLP Phone _____ Primary SLP Email _____

Please provide a brief summary of the dysphagia history:

Has the patient had a swallow study (video swallow or FEES) in the past? If so, what was the outcome and the date of the study?

Please provide any compensatory strategies you would like the speech pathologist to attempt during the study:

Please list consistencies used in therapy and tolerance of these trials (e.g. patient on honey thick, trials nectar thick with coughing):

Relevant Medical History:

Relevant Medications:

Please send to the Speech Language Pathology Department by email, fax, or with the patient.

- **Hospital of the University of Pennsylvania** | Phone (215) 662-3240 | Fax (215) 662-6719 | Email Penn.HUPSLP@uphs.upenn.edu
- **Penn Presbyterian Medical Center** | Phone (215) 662-9604 | Fax (215) 662-9855 | Email Penn.PPMCSLP@uphs.upenn.edu
- **Pennsylvania Hospital** | Phone (215) 829-5587 | Fax (215) 829-7852 | Email Penn.PAHSLP@uphs.upenn.edu