## Video Fluoroscopic Swallow Study Intake Form (SLP)

<table>
<thead>
<tr>
<th>Patient Name __________________________</th>
<th>Referring Physician __________________________</th>
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<tbody>
<tr>
<td>Anticipated Date of Study _____________</td>
<td>Current Diet __________________________________</td>
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**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: