



Patient

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Examination Required

Videofluoroscopy Swallow Study

Attn: Alanna Bowen
Email to: admin@alannabowenspeechpathology.com

PLEASE BRING PREVIOUS FILMS FOR COMPARISON

IV Contrast Alert

Contrast Allergy

Yes No

Renal Disease

Yes No

Diabetes Metformin treatment

Yes No

Creatinine level:

eGFR:

Date:

MRI

Indicate whether the following applies to your patient.

History of welding, grinding, sheet metal work

Yes No

Cardiac pacemaker

Yes No

Brain aneurysm clip

Yes No

Cochlear implant

Yes No

Intravascular coils, filters, stents

Yes No

Obstetric Ultrasound Previous Uterine surgery/ Instrumentation

Yes No

Number:

Date LMP:

Clinical Notes

Circle all that apply:
Dysphagia with solids
Dysphagia with liquids
Concerns re aspiration
Structural concerns eg cricopharyngeal dysfunction, pharyngeal pouch

Referring Doctor (Please include provider no. and CC Dr.)

Staff Use Only:

Time out section - tick to complete:

Correct Patient verified

Correct procedure, side & site

Correct Patient data

Patient consented and form signed

Signature

Date

Films & Report

With patient Fax Request for new referral pads

Your doctor has recommended that you use I-MED Radiology. You may choose another provider but please discuss this with your doctor first.