

Swallowing Test

Patient Information:

Name:

Date of Birth:

Medical Record Number:

Date of Assessment:

Referring Physician:

Clinical History:

Reason for Swallowing Test:

Presenting Symptoms:

Pre-Assessment Screening:

Medical History:

Current Diet:

Objective Assessment:

Clinical Observation:

Trial Swallows:

Instrumental Assessment (if applicable):

Videofluoroscopic Swallow Study (VFSS):

Fiberoptic Endoscopic Evaluation of Swallowing (FEES):

Results and Recommendations:

Summary of Findings:

Recommendations:

Follow-Up Plan: