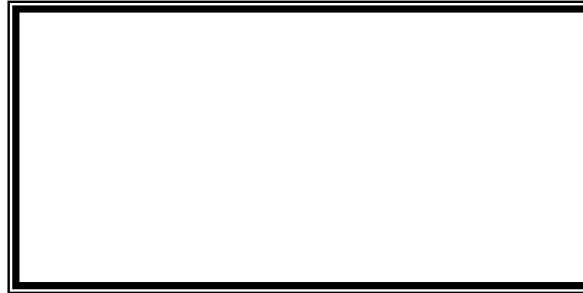


Speech & Language Therapy Service

Referral for Assessment of:  
**Voice**

Attach PAS Label:



Presenting Complaint:	Onset:	
Voice Quality: [in clinic]		
Vocal cords [on endoscopy]	<input type="checkbox"/> AP constriction <input type="checkbox"/> False cord adduction <input type="checkbox"/> Nodules <input type="checkbox"/> Papilloma <input type="checkbox"/> Swallowing Problems <input type="checkbox"/> Unilateral VC palsy R / L	<input type="checkbox"/> Bowing <input type="checkbox"/> Leukoplakia <input type="checkbox"/> Reinke's oedema <input type="checkbox"/> No abnormality detected <input type="checkbox"/> Phonatory gap <input type="checkbox"/> Bilateral VC palsy R / L
	<input type="checkbox"/> Other [please specify] _____ _____ Comments: _____ _____ _____	
Endoscopy completed ? <input type="checkbox"/> Yes <input type="checkbox"/> No [Tick as appropriate]		
Is the current voice problem preventing the patient from work? <input type="checkbox"/> Yes <input type="checkbox"/> No [Tick as appropriate]		
[Tick as appropriate] <input type="checkbox"/> ENT follow-up arranged in _____ weeks. <input type="checkbox"/> ENT follow-up to be requested by Speech & Language Therapist as needed.		
Date: _____ Consultant / SpR _____		