Appendix 2

DYSPHAGIA HOTLINE CLINIC

Patient details:

Date: ……

Date of Referral: ……..

I. Has the patient got true dysphagia Yes/No
If no, what symptoms does the patient have?……..

II. Duration of Dysphagia ….. weeks

III. Is the dysphagia: Progressive Intermittent

IV. Dysphagia to: Solids Liquids

V. Level of Dysphagia: Pharyngeal Mid-sternal Lower sternal

VI. Weight change during duration of symptoms: ……..

VII. Any regurgitation or choking? Yes/No

VIII. Does the patient have:
reflux symptoms Yes/No
odynophagia Yes/No
Any associated chest pain Yes/No

IX. Diet – Has the patient altered their diet as a consequence of their symptoms? Yes/No
If yes, please give details …….

X. Is the patient taking a PPI or H_2 blocker? Yes/No
If yes, please specify drug and effect on symptoms ……..

XI. Tick the following if applicable:-
Warfarin ☐ Diabetes ☐ Asthma ☐ Eczema ☐ Allergies……

XII. Clinical diagnosis: (**Please tick)**

Ca oesophagus	Other Motility Disorder
Peptic stricture	Pharyngeal pouch
GORD	Schatzki ring
Achalasia	Functional (globus phenomenon)
Normal	

Other: please specify ……..

XII. Outcome:
OGD Ba Swallow Ba Swallow & OGD
Other: specify

FOR DEPARTMENT OF RADIOLOGY USE:
Ba swallow findings:

Name of Radiologist: ……..