



t: 215-826-3301 f: 215-798-9647
e: info@neurogenicss.com

Fiberoptic Endoscopic Evaluation of Swallowing (FEES) Consent Form

PATIENT INFORMATION:

Name: _____

Date of Birth: _____

A FEES exam is an instrumental assessment of swallowing using a flexible endoscope (i.e., a small tube with a camera). The endoscope is passed through the nose to the hypopharynx (i.e., the throat). With the endoscope in place, you will eat and drink food/liquids mixed with food coloring. This allows us to directly visualize anatomical structures and to observe swallow function. Results will be discussed after the test by reviewing the endoscopic images.

POSSIBLE ADVERSE REACTIONS:

Note: These reactions are rare but have been reported in the literature:

- Nosebleed
- Fainting (vasovagal response)
- Laryngospasm (i.e., an abrupt tightening of the vocal folds).

BENEFITS OF FEES:

- Identification of a swallowing disorder.
- Identification of loss of airway protective reflexes.
- Recommendations, which may include: diet modifications to prevent food and/or liquid from entering the airway, swallowing rehabilitation exercises or programs, referral to a physician/specialist (e.g., ENT).

I _____ understand that an endoscopic swallowing evaluation has been ordered. The procedure has been explained to me including possible adverse reaction. I give my consent for this procedure and for the recording of this procedure.

____ Initials indicate agreement for repeat procedures if needed during subsequent therapy sessions and/or used for therapeutic intervention. This consent may be withdrawn at any time by notifying by phone: 215-826-3301.

CONSENT GIVEN:

- Verbally via telephone.
- Written in-person.

Print Name

Signature

Date

Witness Name

Signature

Date