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ENT Referral Form

Lamar University
Speech-Language Clinic
Beaumont, Texas 77710
(409) 880-8171

Patient's Name _____ DOB: _____ Age: _____

Address: _____ Phone: _____

Consultant's Name _____

Address: _____ Phone: _____

Patient's complaint/reason for referral and background information:

_____

_____

CONSULTANT'S FINDINGS
(check each item appropriately)

	Normal	Abnormal
1. Ears	( )	( )
2. Hearing	( )	( )
3. Nose & Sinuses	( )	( )
4. Larynx (excluding true vocal folds)		
Size	( )	( )
Shape	( )	( )
Mucous Membrane	( )	( )
Topography	( )	( )
Color	( )	( )

	Normal	Abnormal
5. Vocal Folds		
Length	( )	( )
Thickness	( )	( )
Horizontal	( )	( )
Vertical	( )	( )
Position		
Inspiration	( )	( )
Phonation	( )	( )
Mucous Membrane	( )	( )
Topography	( )	( )
Color	( )	( )
Amount of mucous	( )	( )
Consistency of mucous	( )	( )

If vocal fold pathology is present, indicate on diagrams and checklist R=right, L=left

LOCATION

Anterior commissure	( )	Middle 1/3rd	( )	Posterior commissure	( )
Anterior third	R L	Juntion of the middle		Superior surface	R L
Junction of first		and last 1/3rd	R L	Medial surface	R L
and middle 1/3	R L	Posterior 1/3rd	R L	Inferior surface	R L

SIZE	lateral dimension	anterior dimension
Less than 1 mm	R L	R L
1-2 mm	R L	R L
2-4 mm	R L	R L
more than 4 mm	R L	R L

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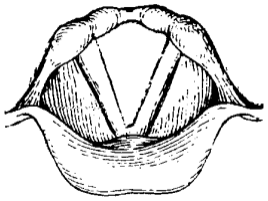
APPEARANCE

Translucent	R	L	Hard, organized	R	L	Sessile	R	L
Opaque	R	L	Soft, organized	R	L	Pedunculated	R	L
White	R	L	Smooth surfaced	R	L	Pointed	R	L
Reddened	R	L	Topographical surface	R	L	Rounded	R	L

NATURE

Scar	R	L	Polypoid growth	R	L
Edema	R	L	Nodular Growth	R	L
Keratosis	R	L	Ulceration	R	L



6. CONDITIONS INFLUCENCING ALTERTED VOICE (when indicating “yes” please enter “1” in the space to suggest a precipitating factor and “2” to suggest a perpetuating factor.)

	YES	NO		YES	NO
Dysplasia	( )	( )	Gonadal	( )	( )
Laryngeal Pathology			Thyroid	( )	( )
Malignant	( )	( )	Menstrual	( )	( )
Non-Malignant	( )	( )	Sicca Syndrome	( )	( )
Myopathy/Neuropathy	( )	( )	Faulty use of the larynx	( )	( )
Endocrine	( )	( )			

CONSULTANT’S COMMENTS _____

_____

_____

CONSULTANT’S MEDICAL DIAGNOSIS

_____

_____

_____

CONSULTANT’S RECOMMENDATIONS

( ) Further diagnostic work-up needed. Specify.
( ) Vocal silence would be helpful.
( ) Limited use of voice would be helpful.
( ) More efficient, easy use of the vocal mechanism would be helpful.
( ) Would like to see individual again. Specify when.
( ) Other: _____
_____
_____
_____

_____

Signature of Consultant Date