HILL COUNTRY DYSPHAGIA DIAGNOSTICS

A MOBILE FEES COMPANY

CONSENT FORM

Client Name: _______________________________

I understand that I will be participating in a flexible endoscopic evaluation of swallowing (FEES) in the near future. The procedure has been explained to me and I understand that this procedure involves placing a small scope with a camera in my nasal cavity. I understand that I have the right to stop the procedure at any time, if necessary.

Client/MPOA Signature: ___________________________________ Date: ____________________

Facility SLP Signature: ____________________________________ Date: ____________________