Table 1: Recorded reason for initial referral and voice outcome measures at initial voice outpatient clinic.

*Abbreviations: * Grade, Roughness, Breathiness, Astenicity, Strain [12]; ** The Voice Handicap Index (VHI) [13]; ***Vocal Tract Discomfort Scale [14]*

Patient	Reason for referral	Days from SLT/ENT screen to initial voice outpatient clinic appointment	GRBAS*	VHI**	VTDS Measures***	Intervention Type
1	"Breathy, asthenic voice quality ranging from mild dysphonia to some periods of complete aphonia"	45	G2 R1-2 B1-2 A2 S1	20/120	Mild consistent dryness, mild occasional tightness and aching	Medication Voice therapy
2	"Moderate-severe dysphonia"	66	G1 R0-1 B1 A1 S0 diplophonia in upper pitch range	67/120	Occasional dryness	Injection medialisation Voice therapy
3	"Hoarse voice"	17	G1-2 R1-2 B1-2 A1 S1-2	Ø Incomplete as difficulties being heard via remote clinic	Previous Soreness.	Voice therapy
4	"Dysphonia"	10	G1-2 R0 B1 A1-2 S0	55/120	Frequent tickling and irritability in the larynx.	Voice therapy
5	"Altered voice that has persisted"	17	NAD	7/20 WNL	NAD	Prednisolone treatment in acute phase Voice care advice and discharge
6	"++quiet. Hoarse, harsh quality"	37	G0-1 R0-1 B0-1 A0 S0-1	Ø Not completed as via remote clinic	Ø Not completed as via remote clinic	Voice care advice

7	"Aphonia"	72	G0-1 R0-1 B0-1 A0-1 S0	7/20 WNL	Frequent mild tickling	Voice care advice and discharge
8	"Severe dysphonia"	31	G0 R0 B0 A1 S0	48/120 *Results impacted by co-existing features of social communication disorder.*	Tightness, aching, soreness, a lump in the throat and dryness	Discharge no follow up

Table 2. Dysphagia presentation and outcome.

Patient	**FOIS at initial assessment (appendix 1)**	**FOIS 3 months post assessment**	**Instrumental assessment**	**Key findings from instrumental ax**	**Hypothesised cause of dysphagia**
1	1	6	Videofluroscopy swallow study	Reduced soft palate elevation leading to escape of contrast to the nasal cavity. Partial epiglottic inversion. Diminished pharyngeal stripping wave and reduced base of tongue retraction. Reduced duration of pharyngoesophageal opening leading to partial obstruction of the bolus through the PES. Collection of residue within the pharyngeal structures. Aspiration of pharyngeal residue.	Cranial neuropathy
2	1	6	Fibreoptic endoscopic evaluation of swallowing	Base of tongue candida and diffuse inflammation throughout the pharynx.	Myopathy

				Swallow initiation prompt with good vestibular closure and epiglottic inversion. Images indicate mild left sided weakness. Vallecular residue was observed with assessment duration.	
3	2	7	No	N/A	Myopathy (myopathic changes on EMG)
4	5	7	Videofluoroscopy swallow study	Swallow initiation at the level of the pyriform sinus. Partial approximation of arytenoids to epiglottic petiole. Incomplete laryngeal vestibule closure. Persistent Laryngeal penetration.	Iatrogenic laryngeal nerve injury