DRAFT

Out Patient Speech & Language Pathology Referral Form

Patient Information

Name: ____

Address: ____

Phone number: _______________________ Date of Birth (dd/mm/yyyy):_____________

Health Card number: ______________________________

Next of Kin Name: ___________________________ Phone Number: ________________

Who should be contact if not the patient?

Same as next of kin ☐ Yes ☐ No (If no, please provide details below)

Name: _______________________________ Phone Number: ______________________

Current Status

Primary Diagnosis & Date of onset	
Secondary Diagnosis	
Summary of History & Physical Examination	

- ❑ Recent Aspiration Pneumonia and hospitalization
- ❑ Frequent Chest Infections
- ❑ Choking episodes (with airway blockage)
- ❑ Date of last choking episode:___________
- ❑ Recent change in health condition causing Dysphagia
- ❑ Unintended recent significant weight loss
- ❑ COPD
- ❑ Oral pharyngeal cancer
- ❑ Neurodegenerative disease
- ❑ Frequent coughing/throat clearing on fluids or solids
- ❑ Increased drooling
- ❑ Occasional coughing/throat clearing on fluids or solids
- ❑ Pocketing of food or spitting of food
- ❑ G tube feed and request to eat by mouth
- ❑ Patient/family requesting to update diet
- ❑ Pharyngeal globus sensation
- ❑ Odynophagia
- ❑ Errorful to swallow
- ❑ Coughing/throat clearing on fluids or solids

Services Requested

- ❑ Swallowing Assessment*
- ❑ Videofluoroscopic swallow study
- ❑ Videofluoroscopic swallow study at discretion of SLP*

** A Physician's referral is required for swallowing assessments **and** VFSS.*

- ☐ Communication Assessment

  Please check all that apply
  - ☐ Aphasia (Receptive/Expressive/Both)
  - ☐ Dysarthria
  - ☐ Voice (ENT examination results must be forwarded with referral)
  - ☐ Cognitive communication
  - ☐ Other ________________________

Has the patient had a swallowing or communication assessment previously?

☐ Yes, Where _________________ Date: ____________________ ☐ No

If yes, please send relevant consult notes

Physician Information

Referring Physician (Please Print)	**Signature**
Copies to:	