Brant Community Healthcare System
The Willett, Paris
The Brantford General

FOR SLP USE ONLY			
RECEIVED:	CLINICAL AX:	VFSS:	FAXED:

Outpatient Swallowing Clinic Referral Form

Brantford General Hospital 200 Terrace Hill St Brantford, ON N3R 1G9
Phone: 519-751-5523 Fax: 519-751-5859

Services Provided
- ✓ Clinical Swallowing Assessment
- ✓ Videofluoroscopic Swallow Study at SLP discretion

Referral Criteria
- ✓ The individual has swallowing difficulties. Referrals will be prioritized based on the details provided.
- ✓ Ability to tolerate appointments, participate in goal-setting, and integrate recommendations into daily life with sufficient cognitive skills, or be accompanied by a caregiver who is able to.
- ✓ Able to travel to and from Brantford General Hospital.
- ✓ Minimum of 18 years of age.
- ✓ **Please consider esophageal investigations first or concurrently if the individual exhibits esophageal signs and symptoms (e.g., globus sensation in the throat or chest, regurgitation, greater difficulty with solids than liquids, excessive eructation, etc.).**
- ✓ **Physician or nurse practitioner signature is required.**

Patient Information

NAME: _____ HCN #: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

DATE OF BIRTH (YYYY/MM/DD): _____ PHONE NUMBER: _____

HEALTH CARD NUMBER: _____

Alternate Contact □ Power of Attorney □ Substitute Decision Maker

NAME: _____ PHONE NUMBER: _____

RELATIONSHIP: _____

TO ARRANGE APPOINTMENTS CONTACT: □ Patient □ Alternate Contact

Swallowing Concern(s) and Medical History (please attach relevant reports, diagnostics, medication lists, etc.)

Describe swallowing concerns (include date of onset):

Current Diet Texture/Consistency:

Solids:	Liquids:
□ Regular	□ Thin
□ Soft and Bite-Sized	□ Mildly Thick (Nectar)
□ Minced and Moist	□ Moderately Thick (Honey)
□ Pureed	□ Extremely Thick (Pudding)

Past Medical History:

Medications (including dosage/frequency):

Relevant Investigations (include date/results): Chest Imaging: Barium Swallow: Upper GI: ENT: Other:	Allergies (include allergic reaction):

Has the patient had a prior swallowing assessment?

□ Yes
□ No

If yes, please provide details (i.e., date, service provider) and send and relevant consult notes.

_____

_____

Family Physician/Nurse Practitioner		
Last Name:	First Name:	Phone Number:
		Fax Number:

Referring Physician/Nurse Practitioner (if different than above)		
Last Name:	First Name:	Phone Number:
		Fax Number:

Copies to:

Signature (required):	**Date:**

A signature on this referral form allows the Speech-Language Pathologist (SLP) to complete a clinical swallowing assessment (CSA) and/or a videofluoroscopic swallow study (VFSS) as clinically indicated. A CSA is required before a VFSS can be completed. The CSA can be done by any SLP. A swallowing assessment report must be sent along with this referral if completed outside BCHS.

Fax completed form (2 pages) to 519-751-5859
Please call 519-751-5523 with any questions

NOTE: Please attach any relevant reports, diagnostics, and a medication profile. Incomplete referral forms will be returned to referral source for completion.

DYSPHAGIA REFERRAL DECISION MAKING

Trouble Swallowing

REPORTS:

- Difficulty initiating the swallow
- Difficulty masticating
- Coughing
- Choking
- Nasal Regurgitation

AND/OR

MEDICAL HISTORY SIGNIFICANT FOR:

- Frequent/Reoccurring Pneumonias
- Stroke
- Head & Neck Cancer
- Respiratory Disease (Ex. COPD)
- Neuromuscular Disease (Ex. Parkinson's)
- Neurocognitive Disease (Ex. Alzheimer's Dementia)

PLEASE CONSIDER:

- Speech Language Pathology Referral
- ***Concurrent*** Esophageal investigations including
  - Barium Swallow
  - Endoscopy
  - Manometry

REPORTS:

- Sticking in the chest/throat
- Prolonged sensation of retention
- More difficulty with solids and/or pills
- Reflux
- Globus sensation
- Frequent burping
- Regurgitation/Vomiting

PLEASE CONSIDER:

- Esophageal investigations ***prior*** to Speech Language Pathology referral including
  - Barium Swallow
  - Endoscopy
  - Manometry

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