

FOR SLP USE ONLY					
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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.

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Patient Information		
ME: HCN #:		
ADDRESS:		
CITY: PROVINCE:	POS	ΓAL CODE:
DATE OF BIRTH (YYYY/MM/DD): PH	ONE NUMBER:	
HEALTH CARD NUMBER:		
Alternate Contact □ Power of Attorney □ Substitute Decision Ma	ker	
NAME: PHONE	NUMBER:	
RELATIONSHIP:		
TO ARRANGE APPOINTMENTS CONTACT: □ Patient □ Alterna	te Contact	
Swallowing Concern(s) and Medical History (please attach rele	evant reports, diagnostics	s, medication lists, etc.)
Describe swallowing concerns (include date of onset):	Current Diet Texture/Consistency:	
	Solids: □ Regular	Liquids: □ Thin
	☐ Soft and Bite-Sized☐ Minced and Moist☐	□ Mildly Thick (Nectar) □ Moderately Thick (Honey)
	□ Pureed	□ Extremely Thick (Pudding)
Past Medical History:	Medications (including	dosage/frequency):
	1	

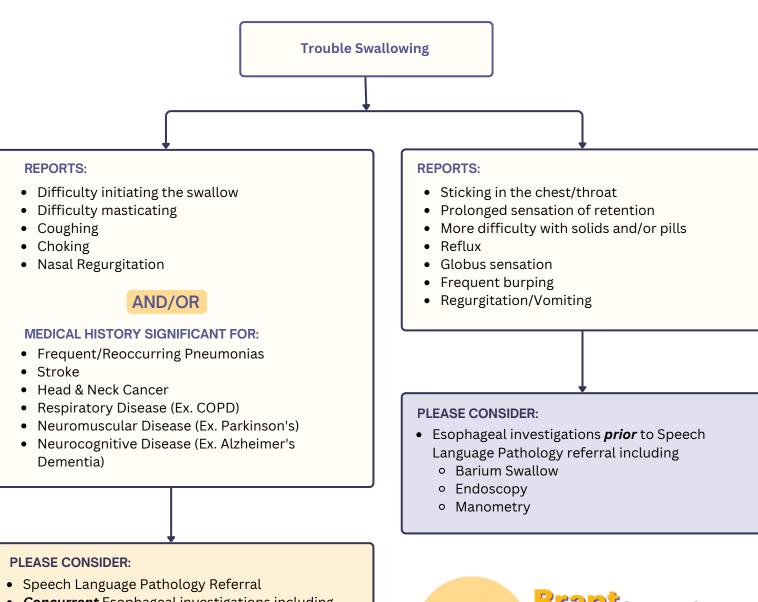
Relevant Investigations (include date/results):		Allergies (include allergic reaction):		
Chest Imaging:				
Barium Swallow:				
Upper GI:				
ENT:	1			
Other:				
Has the patient had a prior swallowing assessment?				
□ Yes □ No				
If yes, please provide details (i.e., date, service provider) and send 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:		
Last Name:		Phone Number: Fax Number:		
Last Name: Copies to:				

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

outside BCHS.

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



- Concurrent Esophageal investigations including
 - o Barium Swallow
 - Endoscopy
 - Manometry

