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Outpatient Swallowing Assessment Referral Form

Services Provided

✓ 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 can.
- ✓ Able to travel to the appropriate catchment area (see back of form)
- ✓ **Please consider esophageal investigations first 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 belching or food sticking at the level of the sternum).**
- ✓ 18 years of age or older

IMPORTANT: Incomplete referrals will be returned to be completed fully.

Patient Information

NAME: _____ HCN #: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

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

Alternate contact ☐ Substitute Decision Maker ☐ Other

NAME: _____ PHONE NUMBER: _____

RELATIONSHIP: _____

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

Current Symptoms:

- ☐ Coughing /choking on liquids or solids
- ☐ Food going down the wrong way
- ☐ Difficulty chewing or clearing food from the mouth
- ☐ Difficulty clearing food from throat or sensation of food sticking
- ☐ Gurgly, wet voice quality after eating or drinking
- ☐ Recent or recurrent pneumonia
- ☐ Reduced oral intake / unintentional weight loss
- ☐ Other:

Current diet texture / consistency:

Liquids:
- ☐ Thin
- ☐ Thickened

Solids:
- ☐ Regular
- ☐ Modified (puree, minced)

Does this patient receive any alternate methods of nutrition such as tube feeding or total parenteral nutrition?

☐ Yes ☐ No

Diagnosis: _____

Please attach the following:

- Past medical history
- Medications (dosage / frequency)

- ☐ Chest imaging
- ☐ Barium Swallow
- ☐ Upper GI
- ☐ ENT
- ☐ Other

Has the patient had a prior swallowing assessment?

☐ Yes ☐ No

If yes, please provide details (date, service provider and relevant notes).

Community Partners Involved?

☐ Yes ☐ No

If yes, please provide further details: _____

Referring Physician / Nurse Practitioner

Name: _____ Date: _____

Signature: _____ **MD** **NP** Phone: _____

Fax: _____

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Catchment Areas
PLEASE FAX REFERRAL TO: **Marotta Family Hospital (SCS)** St. Catharines, Thorold, Grimsby, Vineland, Beamsville, Jordan (X-ray bookings) Fax: 905-323-7593 Phone: 905 378 4647 ext. 46270 **Niagara Falls Site** Niagara Falls, Niagara on the Lake, Virgil, Fort Erie, Crystal Beach, Ridgeway, Sherkston Attention: Speech Language Pathology Fax: 905 358 4957 Phone: 905 378 4647 ext. 53751 **Welland Hospital Site** Welland, Fonthill, Port Colborne, Fenwick, Wainfleet, Dunnville Attention: Speech Language Pathology Fax: 905 735 8491 Phone: 905 378 4647 ext. 33392