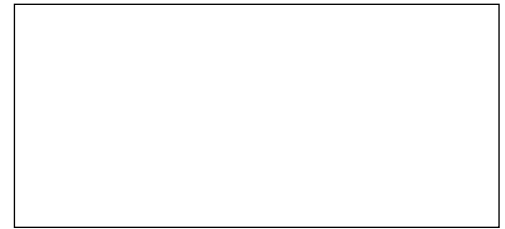




**Lakeridge
Health**

**AMBULATORY REHABILITATION
CENTRES**
Outpatient Speech–Language Pathology
Dysphagia Referral



Whitby Hospital, 300 Gordon St., Whitby, ON L1N 5T2
Tel: 905–668–6831, ext. 53079 Fax: 905–665–2414

Incomplete referrals will delay timely acceptance into the program.

Fax the completed referral form and any relevant physician notes/consultation reports from specialists (e.g. Gastroenterologist, Otolaryngologist, Respirologist and Speech–Language Pathologist).

Order for a Modified Barium Swallow (MBS) study if indicated (check one): Yes No

Applicant Information:			
First Name:	Last Name:	Phone:	
Address:	DOB:	<input type="checkbox"/> M <input type="checkbox"/> F	Alternate:
City:	Province:	Postal Code:	
Primary contact to arrange appointments: <i>(if required & authorized by patient)</i> <input type="checkbox"/> Patient <input type="checkbox"/> Other (specify) Provide name and daytime telephone number if different from individual listed above: _____			
Health Card Number:			
Health Information:			
Primary Diagnosis (please include details)			
Date of Diagnosis:		Date of onset of swallowing difficulty:	
Nutrition <i>(please check one)</i> : <input type="checkbox"/> Oral <input type="checkbox"/> Enteral nutrition <input type="checkbox"/> Both oral and enteral nutrition			
Current Diet Texture <i>(please check one)</i> : <input type="checkbox"/> Regular <input type="checkbox"/> Modified diet texture (specify) _____			
Fluids (please check one): <input type="checkbox"/> Thin <input type="checkbox"/> Mildly thick <input type="checkbox"/> Moderately thick <input type="checkbox"/> Other (specify) _____			
Is this patient's eating/drinking at risk? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) _____			
Family Physician:		Phone:	Fax:
Reason for Referral (referrals will be prioritized based on details provided – please check <u>all</u> that apply)			
<input type="checkbox"/> Recent aspiration pneumonia	<input type="checkbox"/> Takes a long time to eat	<input type="checkbox"/> Request to eat by mouth (enteral nutrition)	
<input type="checkbox"/> Complaints of food sticking in throat	<input type="checkbox"/> Symptoms of dehydration	<input type="checkbox"/> Reassess diet texture/fluid upgrade	
<input type="checkbox"/> Choking episodes	<input type="checkbox"/> Absent or weak cough	<input type="checkbox"/> Increased drooling/saliva	
<input type="checkbox"/> Difficulty initiating swallow	<input type="checkbox"/> Sudden/unexplained weight loss	<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> Coughing or gurgly voice with eating	<input type="checkbox"/> Nasal regurgitation		
<input type="checkbox"/> Chronic respiratory problems	<input type="checkbox"/> Difficulty moving food/drink in mouth		
	<input type="checkbox"/> Pocketing of food in mouth		
Referral Information:			
Person Initiating Referral:		Phone:	Fax:
Referring Facility:	Patient still in Hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes Discharge Date:		
Referring Physician's Name:		Physician's Signature:	
Billing Number:		Date:	

