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:	☐ M ☐ F	Alternate:
City:	Province:		Postal Code:
Primary contact to arrange appointments: *(if required & authorized by patient)* ☐ Patient ☐ 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 *(please check one):* ☐ Oral ☐ Enteral nutrition ☐ Both oral and enteral nutrition			
Current Diet Texture *(please check one):* ☐ Regular ☐ Modified diet texture (specify) _____			
Fluids (please check one): ☐ Thin ☐ Mildly thick ☐ Moderately thick ☐ Other (specify) _____			
Is this patient's eating/drinking at risk? ☐ No ☐ Yes (specify) _____			
Family Physician:	Phone:		Fax:

Reason for Referral (referrals will be prioritized based on details provided − *please check **all** that apply)*

☐ Recent aspiration pneumonia	☐ Takes a long time to eat	☐ Request to eat by mouth (enteral nutrition)
☐ Complaints of food sticking in throat	☐ Symptoms of dehydration	☐ Reassess diet texture/fluid upgrade
☐ Choking episodes	☐ Absent or weak cough	☐ Increased drooling/saliva
☐ Difficulty initiating swallow	☐ Sudden/unexplained weight loss	☐ Other (specify):
☐ Coughing or gurgly voice with eating	☐ Nasal regurgitation	
☐ Chronic respiratory problems	☐ Difficulty moving food/drink in mouth	
	☐ Pocketing of food in mouth	

Referral Information:		
Person Initiating Referral:	Phone:	Fax:
Referring Facility:	Patient still in Hospital? ☐ No ☐ Yes **Discharge Date:**	
Referring Physician's Name:	Physician's Signature:	
Billing Number:	Date:	