Feeding and Swallowing Clinic
3A, 1 Hospital Court
Oshawa, ON L1G 2B9
Tel: 905-576-8711 ext. 36390
Fax Completed Form to the attention of Dr. Amir Elmekkawi: 905-721-7774

FEEDING AND SWALLOWING CLINIC – PAEDIATRICS

PHYSICIAN'S REQUEST FOR FEEDING AND SWALLOWING EVALUATION

Name: _____ **Sex: ( ) M ( ) F** **Date of Birth:** _____
dd-mm-yy

Address: _____ **City:** _____ **Postal Code:** _____

Phone: _____ **Health Card Number:** _____

Medical Diagnosis (if applicable): _____

Current medications and/or vitamins: _____

Please describe the presenting problem regarding feeding/swallowing: _____

_____

_____

Previous medical work-ups performed regarding feeding/swallowing problem (i.e. GI tests, consultations, reports). Please forward copies if available _____

_____

_____

Referring physician: _____ **Billing Number:** _____

Address: _____ **Phone:** _____ **Fax:** _____

Name of the family doctor if different from the referring physician: _____

Signature: _____ **Date:** _____

For the Feeding and Swallowing Clinic visit, the child will be reviewed by a team which may include a Pediatrician, dietitian, and an occupational therapist.