

Outpatient Swallowing Clinic Referral

WRHN @ Chicopee: 3570 King St East Kitchener, ON N2A 2W1
Phone: 519-894-8340 Fax: 519-894-8307

FOR SLP USE ONLY

SLP

Received

Clinic Date

VFSS Appt

☐ Faxed

OUTPATIENT SWALLOWING CLINIC - REFERRAL CRITERIA

- ✓ The individual has swallowing difficulties. Referrals will be prioritized based on details provided.
- ✓ **Please consider esophageal investigations first or concurrently if the individual exhibits esophageal signs and symptoms, such as more difficulty with solids than liquids, globus sensation in the throat or chest, regurgitation.**
- ✓ Able 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 tolerate travel to and from WRHN (Waterloo Regional Health Network).
- ✓ Minimum of 16 years of age.
- ✓ **Physician signature is required.**

SERVICES PROVIDED

- ✓ Services are provided by a Speech Language Pathologist (SLP).
- ✓ Initial swallowing assessment in the Clinic will be completed.
- ✓ Videofluoroscopic Swallow Study (VFSS) WRHN @ Midtown will be completed, if appropriate after initial assessment (optional).

Patient Identification

Last Name	First Name	Initial	Birth Date (year / month / day)
Address	City	Province	Postal Code
Home Phone:	Business/Cell Phone	Health card #	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

Alternate Contact

☐ Emergency Contact ☐ Substitute Decision Maker

Last name	First name	Relationship
Home Phone	Business Phone	Cell Phone

To arrange appointments contact: ☐ Patient ☐ Alternate Contact

☐ Other: _____

☐ Patient/Substitute Decision Maker has consented to messages being left at the above phone numbers

Swallowing Concern(s) and History (Please attach relevant medical reports, diagnostics, medication profile)

Describe the Swallowing Concern(s), including Date of Onset:	Modified Diet Textures (if other than regular):
Ear, Nose and Throat History, including Date of Onset?	Specialist / Date of Last Appointment:
Respiratory History, including Date of Onset (e.g., recent pneumonia, COPD)?	Specialist / Date of Last Appointment:
Gastrointestinal History, including Date of Onset (e.g., reflux)?	Specialist / Date of Last Appointment:

Outpatient Swallowing Clinic Referral Form

CURRENT STATUS / DIAGNOS(ES)	MEDICATIONS / DOSAGES	RELEVANT INVESTIGATIONS
		<div style="text-align: right; font-size: small;">Date / Results</div> <p>CXR:</p> <p>Barium Swallow:</p> <p>Upper GI:</p> <p>Lower GI:</p> <p>Other:</p>
Does this person have a <i>current</i> ARO infection? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please Specify): <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C.Diff <input type="checkbox"/> ESBL		
Allergies (describe allergic reaction)		
<input type="checkbox"/> None known <input type="checkbox"/> Drug allergies _____ <input type="checkbox"/> Food or Environmental allergies _____		
Community Services Involved (Have referrals been made to other agencies or services?)		
<input type="checkbox"/> WRHN @ Chicopee Outpatient Neuro/Geriatric (separate referral required) <input type="checkbox"/> CCAC <input type="checkbox"/> Other <input type="checkbox"/> None		
<input type="checkbox"/> Please specify services: _____		
Transportation (How will the patient get to WRHN?)		
<input type="checkbox"/> Family/Friend will drive <input type="checkbox"/> Mobility Plus/Kiwanis Transit <input type="checkbox"/> Bus or Taxi <input type="checkbox"/> Patient will drive self		
<input type="checkbox"/> Uses mobility aid (Please specify, e.g., wheelchair): _____		
Special Considerations / Comments		
<input type="checkbox"/> Referral form was completed with client/substitute decision maker, and reason for referral has been discussed.		
Referral Source		
Last name	First name	Office phone number
Discipline	Name of service	Date <small>year / month / day</small>
Family Physician		
Last name	First name	Phone Number:
		Fax Number:
Referring Physician		
Last name	First name	Phone Number:
		Fax Number:
Physician Signature (REQUIRED) for SLP Swallowing Assessment and Videofluoroscopic Swallow Study if appropriate		
		Date <small>year / month / day</small>

Fax Completed Form (2 pages) to - Fax: 519-894-8307
Please direct any questions to - Phone: 519-894-8340

NOTE: Please attach relevant reports, diagnostics and medication profile.
All incomplete referral forms will be returned to referral source for completion.