Speech-Language Pathology Out Patient Referral
Please fax completed forms to 1-705-267-6308

Name:_____ Date of Birth:_____
Phone:_____ (dd/mm/yy)

Please ensure that all relevant sections and information are complete to prevent delays in processing this referral. Please attach any pertinent test results or consult notes that may be of importance to the Speech-Language Pathologist.

Primary Diagnosis:

Relevant Medical History:

DYSPHAGIA

□ Swallowing referral**:** *(select type of Swallowing Assessment you are requesting)*

□ Modified Barium Swallow Assessment (MBS) (Please fax DI requisition to the Diagnostic Imaging Dept.)
□ Clinical/Bedside Swallow Assessment

Reason for Swallowing Referral:

□ Documented silent aspiration
□ Sudden weight loss
□ Recurrent/documented aspiration pneumonia
□ Recurrent pneumonia
□ Recurrent temperature spikes
□ Previous swallowing ax *(list)*:
□ Other:

Current Diet:

□ NPO
□ PO (*please specify current diet texture*):

SPEECH/LANGUAGE

Speech/Language Referral: (must be acute – within 6 mos)
Reason for Speech Language referral:

□ **Neuro**
- □ CVA (date:_____)
- □ TBI (date:_____)
- □ Degenerative Disease

□**Surgery**
- □ Laryngectomy (date:_____)
- □ Tracheostomy (date:_____)
- □ Oral Surgery (date:_____)

□**Augmentative/Alternative Communication**
- □ Communication board
- □ Voice Amplification

□ **Other** (please specify):

Referring MD Signature:_____ Date of Referral_____