London Health Sciences Centre

SPEECH-LANGUAGE PATHOLOGY
Outpatient Referral Form

☐ **Victoria Hospital:** Tel. 519-685-8435 FAX: 519-685-8060
☐ **University Hospital:** Tel. 519-663-3517 FAX: 519-663-3378

Date of Referral: _____

Referred By:

Dr.: _____

Phone: _____

Fax: _____

Address: _____

_____

LHSC PIN: .....

Name: .....
Last First

Address: .....

.....

Sex: ..... DOB: .....
YYYY/MM/DD

HC: ..... VC: .....

Home: .....Work/Cell: .....

Reason for Referral:

☐ **Communication** (aphasia, dysarthria, voice, cognitive-communication)

Comments: _____

Onset of Problem: ☐ Acute ☐ Gradual **Are symptoms worsening**? ☐ No ☐ Yes
Duration of Problem: ___Years ___ Months

☐ **Swallowing:** Comments: _____

☐ Coughing after eating drinking ☐ Airway obstruction (unable to speak or breathe)
☐ Foods "sticking" in throat

Onset of Problem: ☐ Acute ☐ Gradual **Are symptoms worsening?** ☐ No ☐ Yes
Duration of Problem: ___Years ___ Months

Unintentional Weight Loss in Last Six Months? ☐ No ☐ Yes If yes, how much? _____lb/kg

Aspiration/Pneumonia/Adverse Respiratory Events? ☐ No ☐ Yes → number in past year? _____

Present Form of Nutrition Intake/Diet: _____

Pertinent Medical History: _____

NOTE: Please attach all relevant reports, diagnostics and medication profile. An incomplete form may delay review of the referral and scheduling of an appointment.

If referral is strictly for communication, you may skip to the signature line on page 2 and fax the referral to 519-663-3378.

Previous Modified Barium Swallow (MBS) Study? ☐ No ☐ Yes ☐ Unknown

If yes, when? _____ Where? _____

Previous Fiberoptic Endoscopic Evaluation of Swallowing (FEES) Study? ☐ No ☐ Yes ☐ Unknown

If yes, when? _____ Where? _____

Mobility: Is your patient ambulatory? ☐No ☐Yes If no, please clarify: _____

Based on the results of your patient's clinical swallowing assessment, we may need to complete an instrumental assessment on the same day, or at a later date. Our instrumental assessment would be a Fiberoptic Endoscopic Evaluation of Swallowing (FEES) and/or a Modified Barium Swallow (MBS) study.

FEES involves the use of nasal endoscopy. Please check off **only if there is a presence** of any of the following conditions:

- ☐ Cardiac Disorder
  - ☐ Vasoconstriction
  - ☐ Elevated heart rate
- ☐ Change in respiration rate in patients with known cardiac symptoms
- ☐ History of vasovagal episodes, or history of fainting
- ☐ Severe bleeding disorders and/or recent, severe epistaxis
- ☐ History of methhemoglobinemia
- ☐ History of recent trauma to the nasal cavity or surrounding tissue and structures secondary to surgery or injury
- ☐ Bilateral obstruction of the nasal passages

PLEASE CHECK THE APPROPRIATE BOX BELOW:

☐ **Patient has one or more of the medical conditions listed above <u>but could tolerate nasal endoscopy</u>**

☐ **Patient has NONE of the medical conditions listed above and <u>can tolerate nasal endoscopy</u>**

☐ **Patient has one or more of the medical conditions listed above <u>precluding nasoendoscopy</u>**

If the SLP determines that an MBS is required, we will contact you to complete an LHSC Radiology requisition.

Thank you for your referral. Referrals will be prioritized based on the information provided. The LHSC SLP Service will contact the patient with an appointment when it is available.

_____

Physician Signature