



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): [] No [] Yes

Comments: _____

Swallowing: [] No [] Yes

Comments: _____

Onset of Problem: [] Acute [] Gradual

Urgency: [] Routine [] Urgent

Duration of Problem: _____ Years _____ Months

Pertinent Medical History: _____

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

Present Form of Nutrition Intake/Diet: _____

History of Aspiration/Pneumonia? [] No [] Yes If yes, when? _____

Previous Modified Barium Swallow Study? [] No [] Yes [] Unknown

If yes, when? _____ Where? _____

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

If yes, when? _____ Where? _____

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

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 methemoglobinemia
- 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 but could tolerate nasal endoscopy
- Patient has NONE of the medical conditions listed above and can tolerate nasal endoscopy
- Patient has one or more of the medical conditions listed above precluding nasoendoscopy

Should we decide that an MBS is required, please complete a London Health Sciences Centre Radiology requisition for an MBS and fax it to 519-663-3378 along with this referral form.

Physician Signature