Baycrest

The Swallowing Clinic Referral Form

The Clinic provides a clinical swallowing assessment by a Speech-Language Pathologist. A Fiberoptic Endoscopic Evaluation of Swallowing (FEES) may be required to complete the assessment.

****Please indicate if you wish your patient to be considered for a FEES procedure: Yes ____ No ____**

Please print all of the following information legibly so that we can better serve our patients.

Name of Patient: _____ Gender: M / F Age: _____

DOB: (D/M/Y) _____ Health Card Number: _____

Address: _____City: _____ Postal Code: _____

Telephone Number(s): _____

****Contact Person:** _____ Relationship: _____

Telephone Number(s): _____

Referring Physician: _____ Phone Number: _____

Address: _____ City: _____ Postal Code: _____

Fax Number: _____ OHIP Billing #: _____

*Physician's Signature: _____

** **Name of Family Physician, if different from referring Physician**: _____

** **Patient's expressed complaint:** _____

Patient's Medical/Health History (brief history & active problems - lab results are not necessary)

Neurological History:

Related History:

ENT &/or respiratory Issues:

Gastric issues/investigations:

Other health history:

** **Please include copies of reports or any other pertinent information from:**

- Previous swallowing assessments
- G.I. assessments
- ENT assessments

Please **fax** this referral to **416-785-5533**. To reach the clinic by telephone, **call 416-785-2500 ext. 2352**