Site: ___________

HRN: Site: DOB: yyyy/mon/dd

Last Name: First and Additional Names:

PHN: Gender: Age in Years:

Admitting Physician: Encounter #:

Address: Street, City, Province, Postal Code

Telephone Number:

Date of Admission: yyyy/mon/dd Family Physician:

Outpatient Dysphagia Clinic Referral Form

Peter Lougheed Centre
3500 - 26th Avenue NE
Calgary, AB T1Y 6J4
Phone: 403-943-4941 Fax: 403-943-4520

Patient Contact Information

Phone: ____________ Fax: ____________

Does this patient have a legal guardian? ☐ Yes ☐ No

Does this patient require an interpreter? ☐ Yes ☐ No If Yes – Language: ____________

Medical History (relevant to swallowing problem)

Pulmonary / Respiratory status: ____________

Neurological diagnosis: ____________

Cancer? ☐ Yes ☐ No ____________ Treated with radiation? ☐ Yes ☐ No

Other: ____________

Medications

History/Duration of Swallowing Problem/Reason for Referral

(Is this a recent change in swallowing status? Swallowing function prior to recent change?)

- ☐ Documented silent aspiration
- ☐ Sudden weight loss
- ☐ Recurrent temperature spikes
- ☐ Suspected/confirmed aspiration pneumonia/recurrent pneumonia
- ☐ Reduced hydration/nutritional status
- ☐ Previous assessment/treatment for feeding and/or swallowing difficulties (please list):

Is this an urgent referral? ☐ Yes ☐ No

Current Method(s) of Feeding and Nutrition

- ☐ **Nothing by Mouth**
  - ☐ PEG (Percutaneous endoscopic gastrostomy tube)
  - ☐ NG (Nasogastric tube)
- ☐ **Method of Feeding**
  - ☐ Self feed
  - ☐ Requires assistance for feeding
  - ☐ Positioning issue
- ☐ **Regular Texture Diet**
- ☐ **Modified Texture Diet**
  - ☐ Thick liquids
  - ☐ Thin liquids
  - ☐ Soft
  - ☐ Minced
  - ☐ Pureed
  - ☐ Other ____________

Recent Diagnostic Reports (please attach results)

- ☐ CT head or MRI brain Date: (yyyy/mon/dd)
- ☐ Chest X-ray or CT chest Date: (yyyy/mon/dd)
- ☐ Upper GI study Date: (yyyy/mon/dd)
- ☐ Esophagram Date: (yyyy/mon/dd)

Is Patient followed by any clinics or specialists? ☐ Yes ☐ No
(please attach recent consult reports)

Please list recent admission to hospital:

Date: (yyyy/mon/dd) Location: ____________

Admitting diagnosis: ____________

Referral Source Information

Referral Source: ____________

Speciality/Professional Designation: ____________ Signature: ____________ Date: (yyyy/mon/dd)

Phone: ____________ Fax: ____________

Please include a signed DI (Diagnostic Imaging) requisition for a MBS (Modified Barium Swallow) and ensure that all sections of the referral form are completed. Incomplete referrals will delay processing of your request.

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