**Referral Instructions: Feeding Swallowing Service - Adult and Pediatric Teams**
**Edmonton Zone**

Feeding Swallowing Service - Adult and Pediatric Teams

Arranging a feeding / swallowing assessment:

**Children – under 18 years of age,** with feeding / and or swallowing problems / dysphagia, should be referred to the:

- **Glenrose Rehabilitation Hospital** – when there is / are *neurological* and / or *developmental* concerns / diagnosis, with or without nutritional concerns

- **Stollery Children's Hospital** – when development is typical and swallowing difficulties are suspected to contribute to frequent respiratory illnesses

**Note:**

- **For preschool children (before school entry) without a *medical, neurological and/or developmental diagnosis*,** please call Preschool Rehabilitation Services Central Intake to make a feeding referral.
(Phone 780 342 6826)

- **Children living in Alberta on home tube feeds –** send referrals to the Pediatric Home Nutrition Support Program (Fax 780 407 8502; Phone 780 407 1341)

**Adults –** may be referred to the **Glenrose Rehabilitation Hospital**

- There is currently a wait for service. Referrals are triaged upon receipt and appointments are scheduled according to clinical urgency.

- If additional information becomes available to you that would affect the urgency of care required, please contact the Glenrose Feeding / Swallowing Service (Phone 780 735 6066) and indicate that you wish to update an existing referral.

**Note:**

- **Services may be available from local providers in Northern Alberta at the following locations:** Vegreville, Camrose, Red Deer, Grande Prairie, Fort McMurray. Please contact health agencies in these cities for more information.

- **Adults living in Alberta on home tube feeds excluding those with nasally placed tubes –** send referrals to the Adult Home Nutrition Support Program (Fax 780 735 4358; Phone 780 735 4236)

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**Complete:**
Outpatient Services Feeding and Swallowing Referral Form CH – 1085 (Rev 2015 – 02)

**Include:**

- □ Completed referral form
- □ Contact information (name and phone number) to arrange appointment
- □ Physician / Nurse Practitioner Signature, Printed Name, Phone and Fax
- □ Guardian name and contact information
- □ Reason(s) for referral
- □ Medical diagnosis
- □ Referral priority
- □ Most recent assessment report
- □ Relevant diagnostic tests (e.g. GI, ENT, Chest X – ray, Allergies)

Please refer to **ONE outpatient location** to avoid duplication of referrals.

**Fax and phone numbers are noted at the top of the form.**

**We look forward to assisting you.**