Alberta Health Services

Outpatient Dysphagia Clinic Referral

Last Name *(Legal)*	First Name *(Legal)*	
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*	
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown		

To confirm specific referral requirements, and where to send referral, visit:www.albertareferraldirectory.ca and search for *Outpatient Dysphagia*

By requesting this referral **you are authorizing** an instrumental swallowing examination, such as Videofluoroscopy or Flexible Endoscopy if clinically required. For questions or concerns, please contact the clinic directly.

Referral Source (name)	Designation/Specialty	Date *(dd-Mon-yyyy)*

Reason for Referral *(check all that apply)*

- ☐ Partial airway obstruction or totally obstructed airway requiring abdominal thrust to clear
- ☐ Sensation of food/liquid entering the airway
- ☐ Throat clearing or coughing during meals
- ☐ Gurgly, wet voice during meals
- ☐ Increased shortness of breath or respiration rate during meals
- ☐ Sensation of food or liquid stuck in throat
- ☐ Unintentional weight loss due to difficulty swallowing
- ☐ History of recurrent pneumonia

Relevant History *(provide more details for medical conditions checked below)*

☐ Respiratory ☐ Cardiovascular ☐ Gastroenterological ☐ Rheumatological
☐ Neurological ☐ Cancer ☐ Head and Neck Surgery

(provide details for conditions checked) _____

Additional Comments *(onset and severity of symptoms, suspected etiology, patient reported symptoms, etc.)*

Specialists/Consults to other services *(provide details)*

Referral Source Signature	Phone	Fax