

## Outpatient Services Feeding and Swallowing Referral

Last Name	
First Name	
PHN#	Birthdate (dd-Mon-yyyy)
Gender	

Please complete **all** sections and fax to **ONE** of:

<b>Pediatric</b> <i>Children with typical development</i> Stollery <b>780.407.6586</b> (Phone 780.407.8859) <i>Children with developmental / neurological issues</i> Glenrose <b>780.735.7930</b> (Phone 780.735.6066)			<b>Adult</b> Glenrose <b>780.735.7930</b> (Phone 780.735.6066)		
Phone number		Alternate phone number		Mailing address	
City/Town		Province	Postal code	Name of family physician (print)	
Name of contact (for appointment arrangements)				Phone number	
Guardian(s)				Relationship to patient	
Goal of Care / Code Status				Phone number(s)	
Is this a work-related injury or WCB claim? <input type="checkbox"/> No <input type="checkbox"/> Yes				Fax number(s)	
<b>Origin of referral</b> Name of Location					
<input type="checkbox"/> Acute care		<input type="checkbox"/> Rehabilitation		<input type="checkbox"/> Facility living	
<input type="checkbox"/> Home living		<input type="checkbox"/> Physician's office		<input type="checkbox"/> Supportive living	
Non MD / NP clinical contact name (e.g. referring OT)				Phone number	
<b>Order</b> [Feeding / swallowing assessment and management with videofluoroscopy and / or endoscopy (where available) as required]					
<input type="checkbox"/> Physician		<input type="checkbox"/> Nurse practitioner			
Name		Signature		Practice ID	
				Date	
<b>Referring Physician / Nurse Practitioner</b> <input type="checkbox"/> Referral source does <b>not</b> require a copy of the report					
Name (print)			Address		
City		Province		Postal Code	
Phone			Fax		
<b>Reason for referral</b> (signs / symptoms of <b>oropharyngeal dysphagia</b> )				Relevant diagnoses	
<input type="checkbox"/> Nutrition concerns <input type="checkbox"/> Hydration concerns <input type="checkbox"/> History of aspiration pneumonia <input type="checkbox"/> Recurrent / chronic chest congestion / pneumonia / COPD <input type="checkbox"/> Query non-oral feeding <input type="checkbox"/> Query return to oral feeding <input type="checkbox"/> Anxiety about swallowing <input type="checkbox"/> More than 1 recent choking / near obstruction event <input type="checkbox"/> Coughing <input type="checkbox"/> Sensory / behavioural issues <input type="checkbox"/> Pre / Post surgical assessment <input type="checkbox"/> Follow up from previous assessment (must send reports)				<input type="checkbox"/> Reassess diet texture <input type="checkbox"/> Reassess fluid consistency <input type="checkbox"/> Regurgitation <input type="checkbox"/> Fluids <input type="checkbox"/> Solids	
Date(s) _____ Location _____				Other concerns, specify	
<b>Referral priority</b> (wait times vary with demand)					
<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low					
<b>Special needs</b> (transfers, self-care assistance, supervision, interpreter)					