Hamilton Health Sciences

Adult Outpatient Swallowing Clinic Referral Request

McMaster Children's Hospital Site - 3V1 / ENT Clinic
PHONE: 905-521-2100 Ext. 73079

Please fax referral to: 905-521-8552 – **Attention:** SLP

Patient's Last Name	First Name	
Address – Street	City	Postal Code
Telephone: ( )	Ext.	
Cell Phone: ( )		
Date of Birth (yyyy/mm/dd)	Age	Gender ☐ M ☐ F
HIN	Family Physician	

Referral Date (yyyy/mm/dd) _____

Referring Physician (print) _____

Referring Physician Signature _____

Phone _____ (ext) _____

Fax _____

OHIP Billing Number _____

Date of previous swallow assessment: (yyyy/mm/dd) _____

Location: _____

Name of professional: _____

Reason for Referral: _____

_____

Medical History significant for: _____

_____

_____

_____

Medications: _____

_____

_____

I request: ☐ A swallowing assessment be conducted for this patient, including Videofluoroscopic Swallowing Study (VFSS)

and / or ☐ Flexible Endoscopic Evaluation of Swallowing (FEES) , if indicated and as determined by the Speech Language Pathologist.

Status: ☐ **Urgent** ☐ **Non-Urgent**

MANDATORY (if test requested) → ☐ Completed & signed VFSS req attached ☐ FEES Request form attached

SLP Impression/Observation of issue: _____

_____

_____

SPL Printed Name _____ SLP Signature _____

704501 (2017-06)

Hamilton Health Sciences

DIAGNOSTIC IMAGING REQUEST FOR CONSULTATION

❑ General ❑ Juravinski ❑ McMaster ❑ WLMH

Appt. Date & Time: _____ (dd/mm/yyyy) (hh:mm)

Patient Last Name First Name

APT # Street Address

City P.C.

HIN Version Code

Patient's DOB Age Sex M F

(dd/mm/yyyy)

WSIB # / Other Ins.

Meditech Unit #

Meditech Acct #

Date Order Requested: (dd/mm/yyyy) _____

Referral Location (Ward/Clinic) _____

Mode of Transportation: ❑ Portable ❑ Wheelchair ❑ O_2 ❑ Stretcher ❑ Crib ❑ Bed ❑ **PUMP**

❑ **ISOLATION** ❑ **Other** _____

Diabetic: ❑ Yes ❑ No

Asthmatic: ❑ Yes ❑ No

Heart Disease: ❑ Yes ❑ No

Medications: ❑ **Metformin/Glucophage** ❑ **Avandamet** ❑ **Coumadin** ❑ **Others:** _____

Renal Function: Serum Creatinine Level _____ **Date:** _____ (dd/mm/yyyy)

Allergies: ❑ Not Known ❑ **YES - Details** _____ or ❑ **Meditech Allergy form SF 710011**

Pt. Pregnant: ❑ **No** ❑ **Yes - LMP** (dd/mm/yyyy) _____

Prev. pertinent Images - ❑ No ❑ Yes - if yes, exam & date done _____ (dd/mm/yyyy)

CLINICAL HISTORY	EXAMS REQUESTED	COMPLETION BY TECH			
		Number Views	Fluoro Time	Exp Factors	Initials
	Videofluoroscopic Swallow Study with SLP				

Physician Doing Procedure: _____

Completion Date: (dd/mm/yyyy) _____ Time: (hh:mm) _____

Physician's Signature Telephone / Ext / Pager Number

Call Report ❑ No ❑ Yes

Print Physician's Name

Copies To:

Copies To:

Charting Notes: (COMPLETION BY Health Care professional)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Printed Name

_____

Signature and Designation

Patient identified: Birthdate ____ Armband ____ Address ____

Patient Pregnant: Yes ____ No ____

Consent obtained: N/A ____ Verbal ____ Written ____

Lead Protection: Yes ____ No ____

1/2 Apron ____ Full Apron ____ Thyroid ____ Breast ____ Gonadal ____

Patient Held by: Family ____ Staff ____ Parent ____ Other ____

Holder Pregnant: Yes ____ No ____

Lead Worn: Full Apron ____ Thyroid ____

Jewellery / Valuables - Items removed: _____

Given to family ____ Given to patient ____

Patient removed and retained ____ Put into envelope/container ____

Replaced on patient Yes ____ No ____

Signature: Patient/Designate _____

Witness _____

Exchange of Information was performed as per Department Policy

Hamilton Health Sciences

Adult Outpatient Swallowing Clinic - Flexible Endoscopic Evaluation of Swallowing (FEES) Request

McMaster Children's Hospital Site - 3V1 / ENT Clinic
PHONE: 905-521-2100 Ext. 73079

Please fax referral to: 905-521-8552 – **Attention:** SLP

Patient's Last Name	First Name	
Address – Street	City	Postal Code
Telephone: ( )	Ext.	
Cell Phone: ( )		
Date of Birth (yyyy/mm/dd)	Age	Gender ☐ M ☐ F
HIN	Family Physician	

Request Date (yyyy/mm/dd) _____

"I request that a *flexible endoscopic evaluation of swallowing (FEES)* be completed for this patient, with Xylometazoline 0.1% (Otrivin) (1-2 sprays per nare) and/or Lidocaine Spray (1-2 sprays per nare) PRN if deemed necessary and appropriate by the assessing Speech-Language Pathologist."

Physician Printed Name _____ Signature _____

Phone: _____ Fax: _____

The following conditions *may* preclude your patient from participating in FEES. Please check all that apply:

- ☐ Acute cardiac issues within the past 30 days
- ☐ Oxygen requirements greater than 50%
- ☐ History of vasovagal episodes or history of fainting
- ☐ History of nose bleeds or severe bleeding disorders
- ☐ On full-dose anticoagulation
- ☐ History of methhemoglobinemia
- ☐ History of recent trauma to the nasal cavity or surrounding areas, secondary to surgery or injury
- ☐ Previous allergic reaction to decongestant
- ☐ Previous allergic reaction to any of the 'caine' anesthetics
- ☐ Any monoamine oxidase inhibitors in the previous 2 weeks

*If you have questions regarding FEES, such as whether your patient might be a candidate for a FEES evaluation, please contact the Speech-Language Pathologist at (905) 521-2100 ext. 77065.