McMaster University Medical Centre
HAMILTON HEALTH SCIENCES

Adult Outpatient Swallowing Clinic
Hamilton Health Sciences
Referral Form

Patient Demographic:

Please fax referral to: 905-521-8552
Attention: SLP
Phone: 905-521-2100 ext. 77065
Address: 3V1 / ENT Clinic
McMaster Children's Hospital
1200 Main St W.
Hamilton, ON

Reason for referral: _____

Past medical history:_____

_____

Medications:_____

_____

Previous swallowing-related investigations: (eg. barium swallow, gastroscopy, laryngoscopy, etc); please include date, results, and attach relevant documentation:

_____

Allergies: _____

I request that a swallowing assessment be conducted for this patient, including *videofluoroscopic swallowing study* and/or *flexible endoscopic evaluation of swallowing*, if indicated and as determined by the Speech-Language Pathologist. (Attached FEES order form and VFSS requisition MUST be completed and included with referral)

STATUS (circle one): URGENT NON-URGENT

*Please contact the speech-language pathologist directly at (905)521-2100 ext. 77065 to discuss urgency and obtain current wait list times.

☐ **COMPLETED AND SIGNED REQUISITION / ORDER FORMS ATTACHED**

Physician's Signature: _____

Physician's Name:_____

Date of Referral:_____

Telephone: _____Fax: _____

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HAMILTON HEALTH SCIENCES

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FEES Order Form

Patient Demographic:

FEES ORDER FORM

Physician order / request for outpatient FEES (flexible endoscopic evaluation of swallowing):

"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 name Physician signature

Physician phone: _____

Physician fax: _____

Comments: _____

_____

_____

*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.

704501 (2014-09)

Hamilton Health Sciences

DIAGNOSTIC IMAGING REQUEST FOR CONSULTATION

☐ General ☐ Juravinski ☐ McMaster

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

Pat Name Last 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 c 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