Adult Outpatient Swallowing Clinic
Hamilton Health Sciences
Referral Form

Patient Demographic:

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: ____________________________

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
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.