GRAND RIVER HOSPITAL

Outpatient Swallowing Clinic
Referral

Grand River Hospital, Freeport Site: 3570 King St East Kitchener, ON N2A 2W1
Phone: 519-894-8340 **Fax:** 519-894-8307

FOR SLP USE ONLY		SLP	
Received	Clinic Date	VFSS Appt	❒Faxed

OUTPATIENT SWALLOWING CLINIC - REFERRAL CRITERIA

- ✓ The individual has swallowing difficulties. Referrals will be prioritized based on details provided.
- ✓ **Please consider esophageal investigations first or concurrently if the individual exhibits esophageal signs and symptoms, such as more difficulty with solids than liquids, globus sensation in the throat or chest, regurgitation.**
- ✓ Able to tolerate appointments, participate in goal-setting, and integrate recommendations into daily life with sufficient cognitive skills, or be accompanied by a caregiver who is able to.
- ✓ Able to tolerate travel to and from Grand River Hospital.
- ✓ Minimum of 16 years of age.
- ✓ **Physician signature is required**.

SERVICES PROVIDED

- ✓ Services are provided by a Speech Language Pathologist (SLP).
- ✓ Initial swallowing assessment in the Clinic will be completed.
- ✓ Videofluoroscopic Swallow Study (VFSS) at the KW site will be completed, if appropriate after initial assessment (optional).

Patient Identification

Last Name	First Name	Initial	Birth Date (year / month / day)
Address	City	Province	Postal Code
Home Phone:	Business/Cell Phone	Health card #	Sex ❒ Male ❒ Female

Alternate Contact ❒Emergency Contact ❒Substitute Decision Maker

Last name	First name	Relationship
Home Phone	Business Phone	Cell Phone

To arrange appointments contact: ❒Patient ❒Alternate Contact
❒Other:_____

❒Patient/Substitute Decision Maker has consented to messages being left at the above phone numbers

Swallowing Concern(s) and History (Please attach relevant medical reports, diagnostics, medication profile)

Describe the Swallowing Concern(s), including Date of Onset:	Modified Diet Textures (if other than regular):
Ear, Nose and Throat History, including Date of Onset?	Specialist / Date of Last Appointment:
Respiratory History, including Date of Onset (e.g., recent pneumonia, COPD)?	Specialist / Date of Last Appointment:
Gastrointestinal History, including Date of Onset (e.g., reflux)?	Specialist / Date of Last Appointment:

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Outpatient Swallowing Clinic Referral Form

CURRENT STATUS / DIAGNOS(ES)	MEDICATIONS / DOSAGES	RELEVANT INVESTIGATIONS
		Date / Results CXR: Barium Swallow: Upper GI: Lower GI: Other:

Does this person have a *current* ARO infection? ❒Yes ❒No (Please Specify): ❒MRSA ❒VRE ❒C.Diff ❒ESBL

Allergies (describe allergic reaction)

❒ None known ❒ Drug allergies _____❒Food or Environmental allergies_____

Community Services Involved (Have referrals been made to other agencies or services?)

❒ Freeport Outpatient Neuro/Geriatric (separate referral required) ❒CCAC ❒Other ❒None

❒ Please specify services: _____

Transportation (How will the patient get to GRH?)

❒Family/Friend will drive ❒Mobility Plus/Kiwanis Transit ❒Bus or Taxi ❒ Patient will drive self

❒Uses mobility aid (Please specify, e.g,. wheelchair): _____

Special Considerations / Comments

❒ Referral form was completed with client/substitute decision maker, and reason for referral has been discussed.

Referral Source		
Last name	First name	Office phone number
Discipline	Name of service	Date year / month / day

Family Physician		
Last name	First name	Phone Number: Fax Number:

Referring Physician		
Last name	First name	Phone Number: Fax Number:
Physician Signature (REQUIRED) for SLP Swallowing Assessment and Videofluoroscopic Swallow Study if appropriate		
		Date year / month / day

Fax Completed Form (2 pages) to - Fax: 519-894-8307

Please direct any questions to - Phone: 519-894-8340

NOTE: Please attach relevant reports, diagnostics and medication profile.
All incomplete referral forms will be returned to referral source for completion.