OUTPATIENT SWALLOWING CLINIC REFERRAL FORM

Patient Name:	PHN#:
DOB (dd/mm/year):	Contact Person:
Phone #:	Phone#:
Address:	Relationship:
	Interpreter Required? Y/N Language:

REASON FOR REFERRAL:

- ☐ High risk for imminent hospital admission due to swallowing dysfunction
  - Recurrent pneumonias _____
  - Hydration/nutrition concerns _____
- ☐ Sudden change to swallowing function. Describe: _____
- ☐ Supporting decision making on oral vs. non-oral nutrition _____
- ☐ Progressive worsening of swallowing function. Describe: _____
- ☐ Re-assessment for upgrade in diet. Date/location of last assessment: _____
- ☐ Longstanding swallowing difficulties not yet diagnosed. Describe: _____
- ☐ Other: _____

DIAGNOSES/RELEVANT MEDICAL HISTORY:

- ☐ Degenerative Disease (e.g. Parkinson's, MS) _____
- ☐ Neurological disorder (e.g. stroke, brain injury, NYD) _____
- ☐ Respiratory Conditions (e.g. COPD) _____
- ☐ Post-Surgery (e.g. cardiac, cervical spine) _____
- ☐ Tracheostomy _____
- ☐ Head and neck cancer _____
- ☐ Other: _____

Please read and sign the requested order:
Swallowing assessment with Videofluoroscopy (VFSS) or Flexible Endoscopic Evaluation of Swallowing (FEES) to be completed per SLP recommendation based on clinical exam. Referring Physician: Please print or stamp the following:
Name: _____Phone:_____ Fax:_____

Physician Signature: _____ Date: _____

Consider alternate investigations (e.g. ENT, GI) if patient has:

- sensation of lump in the throat not associated with oral intake
- food feeling stuck at level of sternal notch or below
- GERD as an isolated condition

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Accompanying Documents:

****IMPORTANT: Referrals without the following documents may not be processed**

☐ Specialist consultations (neurology, neurosurgery, spine, GI, ENT, physiatry, geriatrics, respirology etc.)

Current diet: _____

Tube feed: yes no

Mobility: ☐ Ambulatory (mobility aid if any: _____) ☐ Wheelchair

Please send referral form and accompanying documents to the following locations associated to patient community of care:

Outpatient Swallowing Clinics (Urban)

☐ **North Shore**
Lions Gate Outpatient Dysphagia Program
PH: 604-984-5747
Fax: 604-984-5744

☐ **Richmond**
Richmond Outpatient Swallowing Evaluation (ROSE) Clinic
PH: 604-244-5174
Fax: 778-504-9728

☐ **Vancouver**
UBCH Swallowing Clinic
PH:604-822-7192
Fax: 604-822-7903

Outpatient Services (rural communities)

☐ **Powell River**
qathet General Hospital
Fax: 604-485-3208

☐ **Sechelt Hospital**
Fax: 604-885-8635

☐ **Squamish General Hospital**
Fax: 604-892-6047

* **Bella Bella and Bella Coola please fax referral to Lions Gate**