Soldiers' MEMORIAL HOSPITAL Orillia

Speech-Language Pathology
Videofluoroscopic Swallowing Study Referral

fax completed form to 705-327-9140

Date: _____

Request from (Physician Name): _____

Signature*: _____

(*physician signature required for all referrals)

ALL PATIENTS MUST HAVE A CLINICAL SWALLOWING ASSESSMENT PRIOR TO VIDEOFLUOROSCOPIC SWALLOWING EVALUATION

*clinical swallowing assessment can be arranged through a referral to Home and Community Care Services (HCC) 705-792-6270.

This must be completed before a Videofluoroscopic Swallowing Study referral will be processed.

Patient Name: _____ Male Female (please circle)

Address: _____

Phone #: _____

DOB: _____

HCN: _____

Contact/Guardian: _____

Date of clinical swallowing assessment: _____

Name of Speech-Language Pathologist: _____

please ensure clinical swallowing report attached to referral form

please attach copies of imaging/consults (CT, MRI, upper GI series, gastroscopy, x-ray, ENT consult, etc.) pertinent to the problem.

Reason for referral (description of the problem):

PMHx:

Current Diet (texture, average intake, assistance, restrictions):

Communication/Cognitive Status:

Physical Status (ambulatory, wheelchair, etc.):

Form 3536

To be completed by OSMH:
Referral Received (date): _____
Date/Time of VFSS: _____