

**Speech-Language Pathology
Outpatient Swallowing Clinic
REFERRAL FORM**

**Brampton Civic Hospital
(Outpatient Rehabilitation)**
2100 Bovaird Dr. East, Brampton, ON
Phone: 905-494-6540
Fax: 905-494-6498

Note: The program only accepts referrals for patients living within the catchment area of William Osler Health System (WOHS) or patients referred by WOHS-affiliated physicians.

Patient Information

Last Name: _____ First Name: _____
Date of Birth (DD/MM/YY): _____ Gender: Male Female Other
Health Card Number: _____ Version: _____ No OHIP: _____
Address: _____ City: _____ Province: _____ Postal Code: _____
Phone # (primary): _____ Phone # (alternate/cell): _____
E-mail address: _____ Interpretation Services Required; Language: _____
Contact for booking if different than patient (name/relationship/phone): _____

Reason for Referral (referrals will be prioritized based on details provided - please check all that apply)

Assessment and Management of Dysphagia - with the option of Videofluoroscopic Swallowing Study (at the discretion of the Speech-Language Pathologist post screening/clinical swallowing assessment)

Recent aspiration pneumonia
Difficulty/inability initiating swallow
Significant/unexplained weight loss
Choking episodes (i.e. airway blockage)
Rule out aspiration/silent aspiration
Tube feeding, candidacy for oral intake
Pocketing of food in mouth

Chronic respiratory problems
Coughing/throat clearing/wet voice at meals
Aspiration seen on other imaging
Sensation of food/liquid sticking in throat
Difficulty chewing solids
Diet texture advancement
Other: _____

Relevant Patient History

Primary Diagnosis: _____
Past Medical History: _____
Date of Onset/ Injury/ Surgery: _____
Contraindications/ Restrictions/ Other Relevant Information : _____

Referring Physician Information (Please Print)

Referring Physician Name: _____ OHIP Billing Number: _____
Phone #: _____ Fax #: _____ E-mail: _____
Family Physician (If different from above): _____

Signature of Referring Physician: _____ Referral Date: _____

AS PART OF YOUR REFERRAL, PLEASE INCLUDE RELEVANT MEDICAL REPORTS.