Strathroy Middlesex General Hospital site SLP Dept:
Ph: 519-245-5295 ext. 5010   Fax: 519-246-5928

SPEECH-LANGUAGE PATHOLOGY
OUTPATIENT SWALLOWING ASSESSMENT REFERRAL FORM

DATE OF REFERRAL: ______________________

Patient Name: ____________________________________ **D.O.B**.(yr/month/day) __________________________

Address:____

Telephone Number: Home: ___________________ Work: _____________________

Referred By: ____________________________ Telephone: ____________________________________

Description of Problem: ____
____

Onset of Swallowing Difficulties: Acute Gradual Urgency: Routine Urgent
Duration of Problem: ____Years ____ Months

Present Form of Nutrition Intake: Oral Current Diet Consistency: _______________________________________
Tube Feed (Specify)____

Past Medical History : (attach any relevant reports)
____
____

Current Medications:
____
____

History of Aspiration/Pneumonia? No Yes When?_________________

Previous Modified Barium Swallow Study? No Yes When? _______________ Where? ______________

Weight Loss in Last Six Months: No Yes ___________lb/kg loss

Is client ambulatory: No If No, please clarify _______________________________ Yes

Has Client been involved with SLP services:
No Yes SLP Name/Agency: ________________________________ When/Duration _________________

What specific information are you hoping to obtain from this assessment?
____
____
____

Physician's Signature: ____