SWALLOWING CLINIC REFERRAL
(Instrumental Assessment- Modified Barium Swallow Study)

ROYAL VICTORIA REGIONAL HEALTH CENTRE
201 Georgian Drive, Barrie, ON L4M 6M2
Phone: (705) 739-5602 Fax: (705) 739-5688

Name: _____ Referral Date: _____

Address: _____

Phone: _____ DOB: _____ HC#: _____

Referring Physician: _____ Phone: _____ Fax: _____

Family Physician: _____ Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

Date of Clinical Swallowing Assessment **(Required - attach report)**:_____

Name/Agency of Consulting Speech Language Pathologist: _____

ATTACH ALL RELEVANT CONSULTATION REPORTS (e.g., Neurology, ENT, Gastroenterology, Physician consultation notes etc.)

Description / History of the Problem

_____

_____

Relevant Medical History

_____

_____

Current Diet (textures, average intake, assistance)

_____

_____

Goal of Modified Barium Swallow Study

_____

_____

Communication / Cognitive Status (Is patient able to provide informed consent?)

_____

Physical Status (ambulatory, wheelchair, etc.)

_____

_____ _____

Physician Signature Date

Incomplete/illegible referrals will be returned and patients will not be booked until all relevant documentation has been received