Alberta Health Services

Outpatient Services Feeding and Swallowing Referral

Last Name		
First Name		
PHN#	Birthdate *(dd-Mon-yyyy)*	
Gender		

Please complete **all** sections and fax to **ONE** of:

Pediatric	**Adult**
Children with typical development Stollery **780.407.6586** *(Phone 780.407.8859)* *Children with developmental / neurological issues* Glenrose **780.735.7930** *(Phone 780.735.6319)*	Glenrose **780.735.7930** *(Phone 780.735.6066)*

Phone number	Alternate phone number	Mailing address		
City/Town	Province	Postal code	Name of family physician *(print)*	Phone number

Name of contact *(for appointment arrangements)*	Phone number	Relationship to patient
Guardian(s)	Phone number(s)	Fax number(s)
Goal of Care / Code Status	Personal Directive ☐ Yes	☐ No

Is this a work-related injury or WCB claim? ☐ No ☐ Yes

Origin of referral

Name of Location

☐ Acute care ☐ Rehabilitation ☐ Facility living ☐ Supportive living
☐ Home living ☐ Physician's office ☐ Other, *specify* _____

Non MD / NP clinical contact name *(e.g. referring OT)*	Phone number

Order *[Feeding / swallowing assessment and management with videofluoroscopy and / or endoscopy (where available) as required]*

☐ Physician ☐ Nurse practitioner

Name	Signature	Practice ID	Date

Referring Physician / Nurse Practitioner

☐ Referral source does **not** require a copy of the report

Name *(print)*		Address
City	Province	Postal Code
Phone		Fax

Reason for referral *(signs / symptoms of **oropharyngeal dysphagia**)*

☐ Nutrition concerns ☐ Reassess diet texture
☐ Hydration concerns ☐ Reassess fluid consistency
☐ History of aspiration pneumonia
☐ Recurrent / chronic chest congestion / pneumonia / COPD
☐ Query non-oral feeding
☐ Query return to oral feeding
☐ Anxiety about swallowing
☐ More than 1 recent choking / near obstruction event
☐ Coughing ☐ Regurgitation
☐ Fluids ☐ Fluids
☐ Solids ☐ Solids
☐ Sensory / behavioural issues
☐ Pre / Post surgical assessment
☐ Follow up from previous assessment *(must send reports)*
Date(s) _____
Location _____

Relevant diagnoses

Other concerns, specify

Referral priority *(wait times vary with demand)*

☐ High
☐ Medium
☐ Low

Special needs *(transfers, self-care assistance, supervision, interpreter)*