MARKHAM STOUFFVILLE HOSPITAL CORPORATION

381 Church Street
P.O. Box 1800
Markham , Ontario L3P 7P3

SPEECH-LANGUAGE PATHOLOGY

OUTPATIENT REFERRAL - VIDEOFLUROSCOPIC SWALLOWING STUDY (VFSS) - XRAY

VFSS (instrumental) is usually an adjunct to clinical assessment.
If your patient requires VFSS at this time, please submit this referral form.
If you are unsure, you may refer to CCAC Speech Language Pathology for swallowing assessment.
You can refer by calling 1-888-470-2222. CCAC SLP can then refer for VFSS if necessary.

PLEASE FAX COMPLETED REFERRAL TO: 905-472-7134

Name:	**Sex**	**Date of Birth** (DD/MM/YYYY)	**Health Card #**
Address:			**Tel:**
Contact Person Name:			**Tel:**

Medical History / Diagnosis (please do not include Dysphagia):

Reason for Referral / Current Problem:

This procedure takes approximatley 15 minutes (excluding wait time) and requires the patient to sit upright (or stand if able for that length of time. Patient will be ingesting liquids and /or solids mixed with barium. Is there any reason why your patient cannot tolerate this procedure?

☐ No ☐ Yes, please specify _____

Medications:

Current food/liquid textures:

To ensure prompt processing of this referral, please also complete the attached Diagnostic Imaging Requisition form and include it with this referral form.

Physician's Name (PLEASE PRINT CLEARLY)	
Tel:	_____ Signature of Referring Physician _____ Date (DD/MM/YYYY)

Department of Rehab Services and Orthopaedic Clinics - Speech Pathology
909 - 472 - 7000 X - 3446