

**Speech-Language Pathology  
Outpatient Referral - Videofluoroscopic  
Swallowing Study (VFSS) - Xray**

Please fax completed referral to:  
Booking Line: 905-472-7078

**NOTE: Incomplete and / or unsigned  
requisitions will not be processed**

PLEASE PRINT CLEARLY  
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name (Last, First): \_\_\_\_\_  
 Date of Birth (DD/MM/YYYY): \_\_\_\_\_ Sex: F M  
 Health Card #: \_\_\_\_\_ Version Code: \_\_\_\_\_  
 Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Telephone # (Best Daytime): \_\_\_\_\_  
 Alternate #: \_\_\_\_\_  
 Email: \_\_\_\_\_

Date	Referring Provider	Signature	Provider Phone #	Provider Fax #
Contact Person Name (if different from patient)			Contact Person Phone #	
<b>Medical History/Diagnosis (please do <u>not</u> include dysphagia):</b>				
<b>Reason for Referral/Current Swallowing Problem (Select ALL that apply):</b>				
<input type="checkbox"/> coughing/throat clearing during meals only <input type="checkbox"/> choking (airway blockage)/Heimlich/EMS when eating <input type="checkbox"/> nasal regurgitation <input type="checkbox"/> NPO secondary to oropharyngeal dysphagia <input type="checkbox"/> rule out aspiration/silent aspiration <input type="checkbox"/> aspiration observed on other imaging <input type="checkbox"/> unexplained recurrent pneumonias <input type="checkbox"/> differential diagnosis for aspiration as cause of chest changes/status <input type="checkbox"/> history of nasopharyngeal cancer and radiation <input type="checkbox"/> tube feeding, candidacy for oral intake <input type="checkbox"/> diet advancement from liquids only <input type="checkbox"/> progressive neurological disease <input type="checkbox"/> indicated on clinical swallowing assessment <input type="checkbox"/> sensation of food/liquid sticking in throat (not esophagus) <input type="checkbox"/> unexplained significant rapid weight loss <input type="checkbox"/> diet advancement <input type="checkbox"/> caregiver education <input type="checkbox"/> to assist with differential diagnosis <input type="checkbox"/> difficulty/inability to chew solids <input type="checkbox"/> unable to swallow food/liquid (stays in mouth) <input type="checkbox"/> other:				
Has the patient had a clinical assessment by a SLP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was a VFSS recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please include the SLP report with the referral. Other details from SLP assessment:				
<b>Current food/liquid textures:</b>				
<b>Foods/Solids:</b> <input type="checkbox"/> NPO <input type="checkbox"/> pureed <input type="checkbox"/> minced <input type="checkbox"/> soft <input type="checkbox"/> regular <b>Liquids:</b> <input type="checkbox"/> pudding thick <input type="checkbox"/> honey thick <input type="checkbox"/> nectar thick <input type="checkbox"/> thin (regular)				
<b>Medications:</b>				
<b>Food allergies:</b>				
<b>Additional comments:</b>				
This procedure takes approximately 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? <input type="checkbox"/> No <input type="checkbox"/> Yes, please specify:				
<b>Patient and/or Substitute Decision Maker has consented to this procedure:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				



## **MSH Outpatient Referral Videofluoroscopic Swallowing Study (VFSS) Information and Referral Checklist**

### **Is a VFSS right for your patient?**

- It is usually recommended for patients as an adjunct to a clinical swallowing assessment by a Speech-Language Pathologist (SLP).
- If your patient requires a clinical assessment, please contact your Local Health Integration Network (LHIN) at 1-888-470-2222 and request an SLP referral for swallowing. The LHIN SLP will arrange the VFSS referral if it is indicated. Please note that there are specific eligibility requirements that may exclude your patient from accessing this service.

### **Here are a few key details:**

- Takes approximately 15 minutes (excluding wait time)
- Requires the patient to sit upright (or stand) for that length of time
- Requires the patient to ingest liquids and/or solids mixed with barium

### **If you would like to make a VFSS referral:**

- Complete the "Outpatient Referral - Videofluoroscopic Swallowing Study (VFSS) - Xray" form
- Attach/include any SLP clinical swallowing assessment reports (if available)
- Get consent from the patient or substitute decision maker (SDM) and explain the reason for the referral and that it is a radiographic procedure

Please fax the completed form to Booking Line at 905-472-7078

**If the referral form is not completed, signed, and dated, please note that we will not process the referral.**

### **After you have sent the complete referral:**

- If your patient is appropriate for a VFSS, he or she will be contacted by the Booking Department with appointment details. If you or your patient need information about the appointment date/time or need to cancel/change an appointment date/time, please contact them at 905-472-7373 x7020.
- The wait list for your patient's VFSS can vary depending on the number of referrals and priority guidelines that the SLPs use to triage referrals.
- Once the VFSS report is completed, you (and any other physicians you have requested) will receive a copy by fax from the SLP
- If you have specific questions about the procedure or the results, you can contact the SLP by telephone. The contact information will be included in the document you receive.