

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 LHIN Speech Language Pathology for swallowing assessment.
You can refer by calling 1-888-470-2222. LHIN 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:			
<p>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?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes, please specify _____</p>			
Medications:			
Current food/liquid textures:			
Patient and/or Substitute Decision Maker has consented to this procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Diagnostic Imaging Requisition form must accompany this referral form and BOTH must be faxed to the above number.			
Physician's Name (PLEASE PRINT CLEARLY)		<p>_____ Signature of Referring Physician</p> <p>_____ Date (DD/MM/YYYY)</p>	
Tel:			

