Halton Healthcare

Georgetown Hospital
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Phone: 905-873-0111 ext. 8112
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Rehabilitation and Geriatrics Program

SPEECH PATHOLOGY
OUT-PATIENT REFERRAL

Surname: _____ First Name: _____ G#: _____

Date of Birth (d/m/y): _____ Health Card#: _____ Version Code: _____ Sex: M F

Address: _____
(# and Street Name) (Town/City) (Postal Code)

Telephone – Home: _____ Business: _____

Contact Name: _____ Phone # (if different than patient): _____

Referring Physician: _____ Family Physician: _____

REASON FOR REFERRAL (Please check those that apply)

Assessment and Treatment of:

☐ Aphasia (communication disorder CVA, TBI, etc.)

☐ Voice Disorders

☐ Speech Disorders (apraxia, dysarthria, other)

Assessment and Treatment of Dysphagia:

☐ Including Fiberoptic Endoscopic Evaluation of Swallowing (FEES) and/or Videofluoroscopic Swallowing Study (VFSS)

****** FEES Checklist MUST accompany all swallowing assessment referrals – see page 2 of referral. Failure to complete page 2 will result in the referral being sent back to the physician and will cause a delay in the procedure.**

DIAGNOSIS/PERTINENT MEDICAL HISTORY: (PLEASE INCLUDE ANY REPORTS) _____

_____

Additional Comments: _____

Date of Onset: _____ Date of Surgery: _____

Current Medications: (Attach List) _____

Additional Reports to: _____

Physician's Signature: _____ ***Date:*** _____

Physician please print name: _____

FOR OFFICE USE ONLY - **Intake Date:** _____ **Booked:** _____

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Patient Demographics

Rehabilitation and Geriatrics Program

Outpatient Fiberoptic Endoscopic Evaluation of Swallowing Checklist

In order for FEES to occur, the following must be completed:

- Referral must be received by the department clerk
- Outpatient Fiberoptic Endoscopic Evaluation of Swallowing Checklist must accompany referral. Failure to do so will result in the referral being sent back to the physician and will cause a delay in the procedure.

FEES involves the use of nasal endoscopy. There are contraindications to the procedure. Please check off any of the following conditions if **they are present**:

__ Acute cardiac issues within the last 30 days
- __Arrythmia
- __Unstable Angina
- __Myocardial infarction

__Oxygen requirements greater than 50% (i.e. patient is on high flow oxygen)
__History of vasovagal episodes or history of fainting
__History of nose bleeds, severe bleeding disorders
__Patient is on full-dose anticoagulation
__History of methhemoglobinemia
__History of recent trauma to the nasal cavity or surrounding tissue and structures secondary to surgery or injury
__Previous allergic reaction to decongestant
__Previous allergic reaction to any of the "caine" anesthetics
__ Any monoamine oxidase inhibitors (isocarboxazid, moclobemide, phenelzine, selegiline, tranylcypromine) in the previous two weeks

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PLEASE CHECK THE APPROPRIATE BOX BELOW:

☐ **Patient has one or more of the medical conditions listed above <u>but could tolerate nasal endoscopy</u>**

☐ **Patient has NONE of the medical conditions listed above and <u>can tolerate nasal endoscopy</u>**

☐ **Patient has one or more of the medical conditions listed above <u>preventing nasal endoscopy</u>**

I, Dr. _____(Please Print), give consent to the use of 1-2 nebulized sprays of 10mg Lidocaine spray and/or 1-2 sprays of Xylometalsoline 0.1% (e.g. Otrivin) in each nostril for the FEES procedure as needed on the above named patient. Please sign below if agreeable.

Physician Signature _____Date_____