

Deer Lodge Centre, 2109 Portage Avenue
 Winnipeg, Manitoba R3J 0L3
 Telephone 204-831-2526 Fax 204-831-2953

Speech-Language Pathology WRHA Adult Outpatients Referral Form and Information Sheet

Note: Lack of pertinent data **MAY DELAY** the referral process along with scheduling of the patient's appointment. Please complete referral form and include all requested information.

CLIENT INFORMATION					
NAME OF CLIENT		PRIMARY LANGUAGE		INTERPRETER REQUIRED <input type="checkbox"/> Yes <input type="checkbox"/> No	
ADDRESS		POSTAL CODE		PHONE NUMBER	
DATE OF BIRTH <small>D D M M Y Y Y Y</small>		HEALTH CARD NUMBER <small>(MHSC)</small>		PHIN	
				PLEASE CONTACT: <input type="checkbox"/> Client <input type="checkbox"/> Contact Person	
CONTACT PERSON		RELATIONSHIP		PHONE NUMBER	
HEALTH PROVIDERS					
REFERRAL SOURCE		SIGNATURE		PRINTED NAME AND DESIGNATION	
				FAX NUMBER	
ADDRESS		CITY		POSTAL CODE	
PRIMARY CARE PROVIDER		PHONE NUMBER		FAX NUMBER	
SERVICES REQUESTED					
<input type="checkbox"/> SWALLOWING ASSESSMENT REASON FOR REFERRAL (check all that apply): <input type="checkbox"/> Progressive neuromuscular disorder <input type="checkbox"/> Coughing with intake of food or liquids <input type="checkbox"/> Food feels stuck in the throat <input type="checkbox"/> Choking episode(s) requiring abdominal thrusts <input type="checkbox"/> Recurrent chest infections or pneumonias <input type="checkbox"/> Significant weight loss related to reduced intake <input type="checkbox"/> On a modified diet or liquid texture; Assessment requested for safety of diet texture upgrade <input type="checkbox"/> Receives nutrition via G-tube or J-tube; Assessment requested to determine safety of oral intake <input type="checkbox"/> Information required to assist with neurological diagnosis <input type="checkbox"/> Other (specify): <ul style="list-style-type: none"> • <i>Assessment includes clinical assessment with or without Videofluoroscopic Swallow Study (VFSS).</i> • <i>Diagnostic Imaging Exam Requisition MUST be submitted with referral form.</i> • <i>Physician or approved provider's signature REQUIRED for VFSS.</i> 		<input type="checkbox"/> COMMUNICATION ASSESSMENT SERVICES REQUESTED: VOICE <input type="checkbox"/> Voice Clinic with ENT & SLP <input type="checkbox"/> Voice Assessment with SLP <i>(ENT examination results must accompany referral)</i> <input type="checkbox"/> Chronic Refractory Cough <i>(Investigations to rule out serious underlying cause must be completed prior to SLP treatment – please attach copies of chest imaging, Respirology, ENT reports).</i> <input type="checkbox"/> Gender-Affirming Voice Training NEUROGENIC COMMUNICATION <input type="checkbox"/> Aphasia <input type="checkbox"/> Motor Speech <input type="checkbox"/> Cognitive-Communication <ul style="list-style-type: none"> • <i>Neurogenic communication services are for acquired communication impairments secondary to stroke, brain injury or progressive neurological conditions.</i> <input type="checkbox"/> STUTTERING			
MEDICAL DIAGNOSIS (Include date of onset) and CURRENT MEDICATIONS					
RELEVANT IMAGING, SPECIAL TESTS (Fax copies) <input type="checkbox"/> NEUROLOGICAL INVESTIGATIONS: (Neurology report, imaging studies) <input type="checkbox"/> HEAD/NECK/CHEST IMAGING: (MRI head, neck; CT head, neck, chest; Chest X-Ray) <input type="checkbox"/> PREVIOUS SLP INVOLVEMENT					
<input type="checkbox"/> ENT REPORTS: (Nasoendoscopy; Laryngoscopy; Transnasal Esophagoscopy) <input type="checkbox"/> GASTROENTEROLOGY INVESTIGATIONS: (Endoscopy; Manometry; Barium Swallow; pH testing) <input type="checkbox"/> RESPIRATORY REPORTS <input type="checkbox"/> OTHER: _____					
PATIENT IS AWARE AND IN AGREEMENT WITH THIS REFERRAL <input type="checkbox"/> Yes <input type="checkbox"/> No				Date of Referral: <small>D D M M M Y Y Y Y</small>	

LEGEND: CT - Computed Tomography ENT - Ear, Nose and Throat MRI - Magnetic Resonance Imaging SLP - Speech-Language Pathology VFSS - Videofluoroscopic Swallow Study