Baycrest

The FEES Clinic Referral Form

The Clinic provides a Fiberoptic Endoscopic Evaluation of Swallowing (performed by a Speech-Language Pathologist in conjunction with an ENT, as needed) as a follow-up to a completed clinical swallowing assessment. Results and recommendations will be provided to the referring Speech-Pathologist for management.

Please print all of the following information legibly so that we can better serve our patients.

Name of Patient: __________________ ____________________ Gender: M / F Age: _____

DOB: (D/M/Y) ________________________ Health Card Number: ______________________________

Address: _________________________________City: ________________ Postal Code: ______________

Telephone Number(s): ____

Contact Person: ____________________________ Relationship: ______________________________

Telephone Number(s): ____

Referring SLP: _____________________________________ Organization:_______________________

Phone Number: _________________ Fax number: _________________

Referring Physician: _____________________________________ Phone Number: ________________

Address: ____________________________________ City: _______________ Postal Code: _____________

Fax Number: __________________________________ OHIP Billing #: ______________________________

Physician's Signature: ____ - Please note relative contraindications for FEES include: agitation, acute cardiac issues, oxygen requirements, severe movement disorders, history of recent facial fracture or surgery, vasovagal episodes, nose bleeds or fainting.

Contraindications exist for use of decongestant or topical anesthetic? Yes ___ No ___

Name of Family Physician, if different from the referring Physician: ____________________________

Fax No**:** ________________________________

Patient's Medical/Health History (Please list brief history and active problems)

Neurological: (onset dates, if known) ____

Other Relevant Medical History: ____

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Please include copies of reports or any other pertinent information :

- Previous Speech Pathology/Swallowing assessments **REQUIRED**
- List of current medications **REQUIRED**
- G.I. assessments
- ENT assessments

Please **fax** this referral to **647-788-0718** or Email: SpeechPathology@baycrest.org
To reach us by telephone, please **call 416-785-2500 ext. 2375**