Baycrest

The FEES Clinic Referral Form

The Clinic provides a Fiberoptic Endoscopic Evaluation of Swallowing performed by a Speech-Language Pathologist (SLP) in conjunction with an Ear, Nose & Throat (ENT) clinician, as needed. Results and recommendations will be shared with the referring Physician and community SLP (if available) for management.

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

Name of Patient (first, last): ________________________________ Gender: __________ Age: _____

DOB: (dd/mm/yyyy) ____________________ 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: ________________________

Patients Medical/Health History (Please list brief history and active problems)

Neurological: (onset dates, if known) ____

Other Relevant Medical History: ____

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**. To reach us by telephone, please **call 416-785-2500 ext. 2926**