HOME AND COMMUNITY CARE SUPPORT SERVICES
Toronto Central

250 Dundas Street West, Suite 305, Toronto, ON M5T 2Z5 Tel:
416-506-9888 | 1-866-243-0061
Fax: 416-506-0374
www.healthcareathome.ca/torontocentral

REFERRAL FORM FOR HOME & COMMUNITY CARE SERVICES – ADULT SPEECH LANGUAGE PATHOLOGY

Please fax Referral Form(s) to Home and Community Care Support Services Toronto Central : 416-506-0374

Date: D_____ M _____ Y _____

CLIENT INFORMATION

Name: Address:

Telephone number:

Alternate number:

Ontario Health Card #:_____ VC ____ Date of Birth: D _____ M _____ Y _____

Primary Contact POA/SDM (Name and telephone number):

Primary Diagnosis:

Reason for referral:

Swallowing: Yes ☐ No ☐ Communication: Yes ☐ No ☐

PHYSICIAN / **NURSE PRACTITIONER** INFORMATION

Referring Physician / Nurse Practitioner

Physician / Nurse Practitioner Name:

Address:

Telephone number:

Signature: _____

Date:

OHIP billing code:

Eligibility for direct services:
Valid OHIP card
Assessment by a Home and Community Care Support Services Toronto Central Health Care Professional Access is available 24 hours a day, 7 days a week, every day of the year

CONFIDENTIAL WHEN COMPLETED. IF YOU HAVE RECEIVED THIS FORM IN ERROR PLEASE DO NOT COPY OR DISPOSE OF CONTACT 416-506-9888 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.

June 2017, Form /CS-F45

HOME AND COMMUNITY CARE SUPPORT SERVICES
Toronto Central

ADULT SPEECH LANGUAGE PATHOLOGY REFERRAL FORM

Client Name: _____ HC#: _____ VC ____

MEDICAL INFORMATION		
PRIMARY DIAGNOSIS		
SECONDARY DIAGNOSIS		
PROGNOSIS	DIAGNOSIS DISCUSSED	PROGNOSIS DISCUSSED
☐ Improve ☐ Remain Stable ☐ Deteriorate ☐ Maintenance	With Patient ☐ Yes ☐ No With POA/SDM ☐ Yes ☐ No	With Patient ☐ Yes ☐ No With POA/SDM ☐ Yes ☐ No
RELEVANT MEDICAL HISTORY		
SURGICAL OR OTHER PROCEDURE (S)		
MEDICATION (Attached MARs)	Name:_____ Dosage:_____ Frequency: _____ Route:_____ Duration:_____ Name:_____ Dosage:_____ Frequency: _____ Route:_____ Duration:_____ Name:_____ Dosage:_____ Frequency: _____ Route:_____ Duration:_____ Other:	
DIET		
ALLERGIES		

	ORDERS AND CONTRAINDICATIONS	
	TREATMENT WILL BE TAUGHT/REDUCED UNLESS OTHERWISE INDICATED	
	***High Risk Indicators of Dysphagia (*EIS)**	**Lower Risk Indicators of Dysphagia**
	☐ Recent Aspiration Pneumonia and hospitalization ☐ Frequent Chest Infections ☐ Choking episodes (with airway blockage) Date of last choking episode: _____ ☐ Client lives in own home with little external support and reports swallowing difficulties ☐ Recent change in health condition causing Dysphagia ☐ End of Life - Palliative	☐ Increased drooling ☐ Occasional coughing/throat clearing on fluids or solids ☐ Pocketing of food or spitting of food ☐ G tube feed and request to eat by mouth ☐ Client/Family requesting to update diet upgrade
LABORATORY TEST	Please complete Lab Requisition form and specify the start date	
SIGNATURE OF PHYSICIAN:		DATE:

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