

REFERRAL FORM FOR ONTARIO HEALTH ATHOME – ADULT SPEECH LANGUAGE PATHOLOGY

Please fax Referral Form(s) to Ontario Health atHome: 416-506-0374

Date: D _____ M _____ Y _____

PATIENT 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 NoCommunication: 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 an Ontario Health atHome Health Care Professional
Access is available 24 hours a day, 7 days a week, every day of the year

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CONTACT 416-506-9888 AND WE WILL MAKE ARRANGEMENTS TO COLLECT IT.**

ADULT SPEECH LANGUAGE PATHOLOGY REFERRAL FORM

Patient Name: _____ HC#: _____ VC _____

MEDICAL INFORMATION		
PRIMARY DIAGNOSIS		
SECONDARY DIAGNOSIS		
PROGNOSIS	DIAGNOSIS DISCUSSED	PROGNOSIS DISCUSSED
<input type="checkbox"/> Improve <input type="checkbox"/> Remain Stable <input type="checkbox"/> Deteriorate <input type="checkbox"/> Maintenance	With Patient <input type="checkbox"/> Yes <input type="checkbox"/> No With POA/SDM <input type="checkbox"/> Yes <input type="checkbox"/> No	With Patient <input type="checkbox"/> Yes <input type="checkbox"/> No With POA/SDM <input type="checkbox"/> Yes <input type="checkbox"/> 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) Recent Aspiration Pneumonia and hospitalization Frequent Chest Infections Choking episodes (with airway blockage) Date of last choking episode: _____ Patient lives in own home with little external support and reports swallowing difficulties Recent change in health condition causing Dysphagia End of Life - Palliative	Lower Risk Indicators of Dysphagia 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 Patient/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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