Montfort
713, Montreal Road
Ottawa, Ontario K1K 0T2
(613) 746-4621

Name of Patient:
Gender: □ M □ F
Date of Birth (dd/mm/yyyy):
Address:
Phone Number of patient:
Health Card Number of patient:
Contact Person / Relationship:
Phone Number of Contact Person:
Name of Physician:

CONSULTATION REQUEST

SPEECH - LANGUAGE PATHOLOGY Outpatient Clinic

Referral source (name and title):	**Phone Number:** **Fax Number:**

Please indicate services requested:
☐ Swallowing
☐ Communication (caused by an acquired neurological condition)
☐ Voice Therapy

Medical history (attach all relevant medical documentation such as MRI, CT, neurology, ENT, or GI reports):

When were the difficulties first noticed, and how frequently do they occur?

Has Speech-Language Pathology been consulted in the past? Please provide details (e.g. name, location, goals, etc.):

Please describe any swallowing or dietary concerns (e.g. odynophagia, coughing with liquids/solids, unintended weight loss, etc.):

Please describe concerns with communication (e.g. speech, understanding, reading, writing, etc.):

Please describe concerns with voice and any associated breathing difficulties:

Physician or Nurse Practitioner signature required:

Signature: _____Date (dd/mm/yyyy):_____

Please note that by signing this referral, you are also consenting to a Videofluoroscopic Swallowing Study, if indicated by clinical exam.

We try to see each client in a timely manner. Please be aware that there is frequently a waiting period

DOSSIER