niagarahealth

Adult Outpatient Speech Language Pathology Services Referral Form

Patient Information:

Name: _____ DOB: _____
First Name Last Name year/month/day

Gender: ☐ M ☐ F ☐ _____ Family Physician: _____

Address: _____
Street City Province Postal Code

Telephone: _____ OHIP: _____

Contact Person: _____ Telephone: _____

Relationship: _____

Reason for Referral:

☐ Swallow Clinic – Videofluoroscopic Swallow Assessment (VFSA)
Site of service: ☐ GNG (Niagara Falls) ☐ SCS (St. Catharines) ☐ WHS (Welland)

☐ Speech and Language Services
Site of service: ☐ GNG (Niagara Falls) ☐ WHS (Welland)
(For residents of St. Catharines, please refer to Hotel Dieu Shaver Rehab)

☐ Aphasia ☐ Speech
☐ Cognitive Communication ☐ Voice (WHS only)
☐ Fluency ☐ Other: _____

Medical History: (please include any relevant reports e.g. ENT reports, GI studies, etc…)

Referral Date: _____Referring Physician: _____

Date Received: _____ Referring Physician Signature: _____

PLEASE FAX REFERRAL TO:

GNG – Niagara Falls
(Melissa Bedell, SLP)
Fax: 905 358 4957
905-378-4647
ext.53751

SCS - St. Catharines
(X-ray bookings)
Fax: 905 323 7560
905-378-4647
ext.46270

WHS - Welland
(Jenny Law, SLP)
Fax: 905 735 8491
905-378-4647
ext.33392