REQUISITION FORM FOR VIDEO FLUOROSCOPIC SWALLOWING ASSESSMENT

PATIENT INFORMATION

Name: _____

Preferred Name: _____

Sex (as per OHIP) ☐ Female ☐ Male Identifies as: _____

Date of Birth: ____ / _____ / _____
Day Month Year

Health Card Number: _____

Video fluoroscopic Swallowing Exam (VFSE): ☐

Appointment Date: _____ Time:_____

LOCATION: Medical Arts Building, 1 Young Street, Hamilton Ontario L1N 1T8 T: 905 522-2344

Confirm Patient:

____ Is not pregnant
____ Is not on any medication contra to contrast materials
____ Does not have allergies to contrast material
____ Will wear loose and comfortable clothing

Also, please indicate:

- ➔ Does the individual have ambulatory requirements (e.g., is patient in a wheelchair)? Yes__ No__
- ➔ Is patient able to understand and follow simple directions? Yes__ No__
- ➔ Is the patient currently eating and drinking by mouth? Yes__ No__
- ➔ Is the patient on a modified texture diet? Yes__ No__ ***(If yes, please provide details below)***

Referring Physician Signature: _____**Date Ordered**: _____

Clinical Indications, History or Relevant Information (reason for exam):

Copies To: attending Speech-Language Pathologist
and also copies to: _____