REQUISITION FORM FOR VIDEOFLUOROSCOPIC SWALLOWING ASSESSMENT

PATIENT INFORMATION

Client Name: _____ Date of Birth: _____ / _____ /_____
Day Month Year

Address: _____

Phone: _____ Health Card Number: _____

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

REFERRING PHYSICIAN INFORMATION

Name: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

LOCATION: Medical Arts Building, 1 Young Street, Hamilton, Ontario, L1N 1T8 P: 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 patient have ambulatory requirements (e.g. walker, 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*)

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

Copies to: _____

info@whxray.com **www.whxray.com**

PLEASE FAX TO 905-592-4799