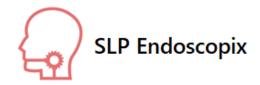
VOICE THERAPY REFERRAL FORM



SLP Endoscopix is now offering voice therapy services! Given a recommendation and clearance from an ENT, voice therapy sessions may be booked with a trained speech-language pathologist (SLP).

Please complete the following form, prior to booking the initial assessment.

PATIENT INFORMATION:			
Name:	DOB (M/D/Y):	Gender (M/F):	
Address:	City:	Postal Code:	
Patient's Phone #:	OHIP #:		
PATIENT'S MEDICAL INFORMA	ATION:		
Diagnosis:		Date of Onset:	
Other relevant medical information	tion:		
Recommended follow-up with E	ENT (indicate date):		
REFERRING PHYSICIAN:			
Name:	Phone #:	Fax #:	
Address:	City:	Postal Code:	
Physician's signature:		Date:	

Please fax this form to 416.981.7733 or email to ilana@slpendoscopix.com