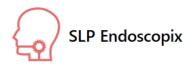
FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING (FEES) REFERRAL FORM



North Toronto ENT Associates 520 Ellesmere Rd. Suite 401 Scarborough ON M1R OB1

SLP Endoscopix is now offering **Fiberoptic Endoscopic Evaluation of Swallowing (FEES) at North Toronto ENT Associates.** This is a safe, effective and objective instrumental assessment of swallowing, which is completed in office by a trained speech-language pathologist (SLP), in conjunction with an otolaryngologist (ENT), as required.

Please complete the following form, prior to booking the evaluation. This form will serve as a referral for ENT consultation/follow-up, and for FEES biofeedback sessions, as required.

Name:	DOB (M/D/Y):	Gender (M/F):
		Postal Code:
Contact Person:	Relationship:	Phone Number:
PATIENT'S MEDICAL HISTO	DRY:	
Diagnosis:	Date of Onset:	·
Other relevant medical inform	mation:	
REFERRING PHYSICIAN:		
Name:	Phone #:	Fax #:
Address:	City:	Postal Code:
Please indicate whether th	e patient has any contraindicati	ons for:
movement disorders, passage, nosebleeds/ > Lubricant, deconges > Food dye (these incluburns, trauma with co	recent trauma to the nasal cavity, recent trauma to the nasal cavity, repistaxis, taking oxygen): Yesstant or topical anesthetic (i.e. alude allergy or conditions that may	
Physician's signature:	I	Date:
TDEATING CDEECH LANCH	AGE PATHOLOGIST (If applicabl	<u>e):</u>
TREATING SPEECH-LANGU		

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

completed as a part of the FEES exam. Please forward relevant GI and ENT reports if available.

FEES is a <u>privately paid</u> exam and a fee will be charged to the patient. Invoices are provided for those with extended health benefits wishing to seek reimbursement