Norfolk General Hospital

**Department of Rehabilitation Services**
**Speech Language Pathology**
***Phone: 519-426-0130 Ext. 2312*** ***Fax: 519-429-6941***

**ADULT OUTPATIENT REFERRAL FORM**

| | |
|---|---|
| **Name:** | **Date:** |
| **DOB:** | **Telephone:** |
| **Address:** | **Referring Physician:** |
| **HC#:** | |

**REASON FOR REFERRAL (Check all that apply):**

- ☐ **Speech and/or language assessment**
- ☐ **Speech and/or language therapy**
- ☐ **Swallowing assessment and follow-up**

**PLEASE DESCRIBE THE PRESENT CONCERNS:**

_____
_____
_____
_____

**Food Allergies (swallowing assessment referrals only):**_____

**RELEVANT DIAGNOSES AND MEDICAL HISTORY:**
***(Please attach relevant reports)***

_____
_____
_____
_____
_____

**SPECIALISTS AND OTHER PROFESSIONALS INVOLVED WITH PATIENT:**

_____
_____
_____

**CONTRAINDICATIONS:**

_____
_____
_____

**Physician's Signature: _____ Date: _____**