UNIVERSITY OF ALBERTA

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Affix patient label within this box

Adult Dysphagia Clinic Patient Referral
1E4, Level 1 Walter Mackenzie Centre
University of Alberta Hospital
8440 112 Street NW, Edmonton, AB, T6G 2B7

Fax this form and related records to (780) 540-2114

Referring Clinician Information (Physician/SLP)			
Name of Clinician:	PRACID:	Address:	
Postal Code:	Phone:	Fax:	
Patient Information			
Last Name:	First Name:	PHN:	Gender: ☐ Male ☐ Female
Address:	Postal Code:	Family Physician:	
Home Phone:	Alternate Phone:	Mobile Phone	

Referral Information

Priority: ☐ Urgent ☐ Routine

Reason for Dysphagia Referral:

☐ Laryngeal pathology suspected (e.g. post-cardiothoracic surgery, post-intubation, etc.)

☐ Structural abnormality suspected

☐ Upper esophageal sphincter / cricopharyngeal dysfunction

☐ Neurogenic / Myogenic / connective tissue disorder

☐ Previous head and neck cancer

☐ Other: ________________________________

Current Patient Location: ☐ In-patient ☐ Out-patient

OFFICE USE ONLY

DATE RECEIVED: ________________________

TRIAGE: P1 P2 P3

Date:____

Signature of Referring Practitioner: ______________________________