**Please indicate if:**

**ODSP/Ontario Works:**  **🞎**

🞎 Physiotherapy

🞎 Occupational Therapy

**□ Hand Therapy**

🞎 Speech Language Pathology

**□ Dysphagia Assessment** – clinical swallow assessment; Videofluoroscopic Swallow Study (VFSS) / Modified Barium Swallow (MBS) to be completed at the discretion of the SLP

**□ Communication** (i.e. language, cognitive-communication, neuro voice disorders, dysarthria, apraxia of speech, articulation, fluency)

🞎 Day Therapy Program (PT, OT, SLP) Patient to be screened by all disciplines

 Intervention and/or discharge will be at the discretion of the therapist involved

🞎 Falls Prevention/Balance Class

🞎 Lymphedema Management (Secondary only as a result of Surgery or Cancer Treatment)

Date of referral:

Diagnosis/Intervention:

Reason for Consultation:

Significant Information/Contraindications:

Date: Referring Physician Signature:

 Print Name: