Bluewater Health

Communication Disorders
Referral Form for Speech-Language
Pathology Outpatient Services

Patient Sticker Here

Date: _____
DD/MM/YYYY

Patient Information:

Name_____ DOB: _____
DD/MM/YYYY

Address _____

Telephone _____

Service Requested:

- □ BSA (Bedside/Clinical Swallow Assessment)
- □ MBS (Modified Barium Swallow)***
- □ Speech/Language
- □ Voice
- □ Cognitive
- □ Other _____

*** MBS studies may be preceded by an initial assessment/BSA at the discretion of the SLP.

Please complete the following for our records:

Referring Doctor's Name (please print):_____

Office Telephone: _____ Office Fax: _____

Medical Diagnosis: _____

Reason for Referral: _____

Doctor's Signature: _____ Date: _____
DD/MM/YYYY

Please return this form, with any pertinent reports to:

Tel: (519) 464 – 4404
Fax: (519) 464 – 4446

Bluewater Health
Communication Disorders
89 Norman Street
Sarnia, ON N7T 6S3

We will contact the patient regarding an appointment

Revised October 2015