stmaryskids
Where big hearts help little patients

Referral for Swallowing Evaluation

St Mary's Hospital for Children
Bayside, NY

Patient Name: _____ DOB: _____/_____/_____
Phone Number: _____ Address: _____

In order to provide the most comprehensive evaluation for your patient, please provide us with the following information:

Present complaint and duration/onset:

_____

_____

Medical history and diagnosis, current weight:

_____

_____

Neurological History? Yes No
If Yes, Please Explain:_____
Pulmonary History (PNA/Respiratory Infections)? Yes No
If Yes, Please Explain: _____
Previous Hospitalizations or Surgery:

_____

_____

Evaluation by ENT or GI:

_____

_____

Has this person received a swallowing evaluation or therapy before? Yes No
If yes, where and when:

_____

_____

Please provide the following evaluations for the above patient:
Please check clinical swallow <u>AND</u> videofluoroscopy for new patients

- □ **Clinical Swallowing Exam**
- □ **Videofluoroscopic Examination (Modified Barium Swallow Study)**

Doctor Name: _____
Address: _____
License#: _____ Ph#: _____ Fax#: _____
MD Signature for Order: _____ NPI#: _____
Date: _____
Please return completed form and send to JoKathleen Rodriguez (718) 281-8505 (fax) or e-mail jkrodriguez@stmaryskids.org. If you have any questions please contact JoKathleen Rodriguez at (718) 281-8809.

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