



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 AND 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 to coordinator to (718) 281-8505 (fax) or e-mail
feedingadmin@stmaryskids.org If you have any questions please contact at (718) 281-8541.

Stamp

