SPEECH-LANGUAGE THERAPY REFERRAL FORM

SLP Endoscopix

Please complete the following form, when a referral is being initiated by a physician or allied health professional:

PATIENT INFORMATION:

Name: _____ DOB (M/D/Y): _____Gender : _____

Address: _____ City: _____ Postal Code: _____

Patient's Phone #: _____ OHIP #:_____

PATIENT'S MEDICAL INFORMATION:

Reason for referral: _____ Date of Onset: _____

Past medical history: _____

REFERRING PHYSICIAN / ALLIED HEALTH PROFESSIONAL:

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ Postal Code: _____

Signature: _____ **Date:** _____

Please fax this form to 416.981.7733 or email to ilana@slpendoscopix.com

Speech-Language Pathology Services are privately paid by the patient. Invoices are provided for those with extended health benefits wishing to seek reimbursement