Dear Colleague:

Patient _____

DOB: _____

In order to facilitate children with swallowing problems, please use the attached form.

This helps us triage your patient to the appropriate combined clinic.

Please fax the completed form back to 780 407-2004 along with the original referral.
The patient will be given an appointment following receipt of this questionnaire.

Thank you kindly,

Dr. Hamdy El-Hakim

Pediatric Otolaryngology
Division of Pediatric Surgery
2C3-57, 8440 - 112 Street
Edmonton, Alberta T6G 2B7
T: 780-407-8629
F: 780-407-2004

Wendy Johannsen, MSLP, R.SLP, S-LP(C)

Speech-Language Pathologist
Pediatric Feeding & Swallowing Service
Stollery Children's Hospital
Phone (780) 407-7449
Pager (780) 445-2900

Stridor / swallowing dysfunction

Age

Gender: Male □ Female □

Stridor Yes □ No □

Choking on liquids/solids Yes □ No □

Pulmonary disease Yes □ No □

Developmental delay (speech, motor, cognitive) Yes □ No □

Syndrome / association Yes □ No □

Blue spells or apparent life threatening episode □ No □

Increased work of breathing Yes □ No □

Snoring Yes □ No □