SPEECH-LANGUAGE PATHOLOGY – Kim Smith, SLP
Voice, Swallowing, Chronic Cough, Upper airway disorders
ABSOLUTE MEDICAL CENTRE
60 Main St. E. Grimsby, Ontario
Phone: (289) 235-7700, FAX: (289) 235-7451

REFERRAL/INTAKE FORM

Patient name: _____ Date of birth: _____

Guardian name: (if applicable) _____ Date of Referral: _____

Address: _____ City: _____ Prov.: _____ Post Code: _____

Telephone: _____ Email: _____

Family (or referring) Dr name: _____ Phone: _____

Reason for Referral/Primary Concern: _____

_____

_____

_____

Relevant medical history:

_____

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_____

Relevant test results:

_____

_____

_____

Current Medications:

_____

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_____

PATIENTS MAY SELF-REFER (PHYSICIAN REFERRAL IS NOT REQUIRED)
PLEASE BRING THIS FORM AND ANY RELEVANT TEST RESULTS/HISTORY WITH YOU TO YOUR FIRST APPOINTMENT, OR ASK YOUR DOCTOR TO FAX THEM AHEAD OF TIME.