REHAB AND WELLBEING CENTRE AT MOUNT SINAI
Joseph and Wolf Lebovic Health Complex

THE VOICE CLINIC

Fill Out / Stamp

Patient Name: _____

Date of Birth: M / D / Y

Address: _____

_____

OHIP #: _____ Ver. Code: _____

Tel: _____

Email: _____

Please Select One:

☐ **Otolaryngology-HNS Assessment Only**

- Stroboscopic Evaluation for diagnostic purposes
- Surgical Intervention

☐ **Otolaryngology-HNS / SLP Joint Assessment**

- Stroboscopic Evaluation + detailed assessment of vocal behaviours/technique by SLP
- *SLP not covered by OHIP; fee will apply*

☐ **SLP Assessment/Treatment**

- No Otolaryngology involvement - diagnosis already established by the referring physician
- Therapy services only
- *SLP not covered by OHIP; fee will apply*

Structural:

☐ Nodules *SLP involvement advised*
☐ Polyp
☐ Reinke's edema/polypoid degeneration
☐ Laryngitis (☐ acute / ☐ chronic)
☐ Presbylarynges or Bowing *SLP involvement advised*
☐ Other: _____

Non-Structural:

SLP involvement advised for all non-structural issues below
☐ Muscle Tension Dysphonia
☐ Vocal Abuse/Misuse
☐ Vocal Fatigue
☐ Transgender Voice
☐ Other: _____

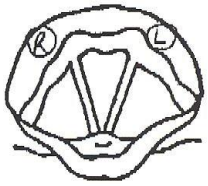
Neurogenic:

☐ Paralysis: (☐ Right / ☐ Left)
☐ Suspected Spasmodic Dysphonia *SLP involvement advised*
☐ Other: _____

Idiopathic Disorders:

☐ Chronic Cough
☐ Paradoxical Vocal Fold Dysfunction *SLP involvement advised*
☐ Congenital Anomaly (specify): _____

Additional Information:



_____
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Fill Out / Stamp

Physician Name: _____

Billing #: *REQUIRED*

Address: _____

_____

Tel: _____

Fax: *REQUIRED*

EMAIL / FAX / MAIL TO:

REHAB AND WELLBEING CENTRE AT MOUNT SINAI – VOICE CLINIC
Rm 1181 - 600 University Avenue
Toronto, ON M5G 1X5
Tel: 416-619-5546 Fax: 416-619-5548
Email: rehabandwellbeing@mtsinai.on.ca

Physician Signature: _____ **Date:** _____