LETTER FOR YOUR DOCTOR

Date_____

Dear Doctor_____

I am concerned about swallowing in

_____ _____
Name of Person Date of Birth

She/He is my: mother father wife husband
other _____

I have noticed these problems over the past
_____ weeks/months: (Circle those that apply)

difficulty swallowing coughing choking gagging
wheezing tearing of eyes runny nose chest pain
nasal regurgitation weight loss fever sore throat
voice change: hoarse weak gargly nasal
frequent throat-clearing tired out by eating nausea
food feels stuck/won't go down drooling heartburn
eating very slowly dehydration refusing food
loose dentures sore gums bad breath
other _____

_____

She/He has these medical problems:
_____
_____
_____

Her/His last hospitalization was _____ (date)
at _____(hospital)
for these reasons: _____
_____

She/He is taking the following medications (prescribed and over-the-counter): _____
_____
_____
_____

I am most concerned about: choking aspiration
pneumonia nutrition hydration
difficulty swallowing pills
Other_____
_____

I look forward to hearing from you at your earliest convenience.

You can reach me in the following ways:

Home Phone ( )_____
Cell phone ( )_____
Fax ( )_____
E-mail _____
Mailing Address _____
_____

Thank you very much for your attention and concern.

Sincerely,

_____
Your signature

_____
Your name printed