HH/OP Referral to DiagnosTEX for Dysphagia Consult with MBSS

Fax referral with order, face sheet, 485 and authorizations to (817) 514-6278 or (888) 920-1201

Patient Name: _____ DOB:_____ Sex: M or F

Street Address:_____ City:_____ Zip:_____

Location is: Private Home ☐ Group Home/Assisted Living ☐ _____ Height:_____ Weight:_____

Scheduling Contact Name:_____ **Phone:**_____ **Relationship:**_____

Ordering Provider (Full Name):_____ Phone:_____ Fax:_____

SLP Full Name:_____ Phone:_____ Fax:_____

Home Health Agency:_____ Phone:_____ Fax:_____

****Fax Report** ☐ **Email Report:**_____

****Reports will be faxed to SLP and Referring for all Home Health Patients to fax numbers above.**

Ambulatory ☐ Walker ☐ Wheelchair ☐ XL Wheelchair ☐ Motorized Chair ☐ Geri Chair ☐

Hospice ☐ **Hospice Agency:** _____ **Hospice DX(s)**:_____

Current: Solids_____ Liquids_____ Trials_____ Strategies_____

Current NOMS:_____ **NPO** ☐ **PEG/NG/J-Tube** AMA diet:_____ ****Allergies**_____

****barium contains natural strawberry and citrus flavor**

☐ **Physician consult requested for dysphagia consultation to include all medically necessary assessments of swallowing function, including Modified Barium Swallow Study (MBSS) for oral and pharyngeal stages, as well as, esophagus and cervical spine assessment.**

Reason for Mobile/Onsite visit is required: **(check all that apply)** Physical condition negatively affected by transport: ☐ Fatigue level concerns and/or medically unstable: ☐ Transportation would negatively affect behavior, cognition and fall risk: ☐ **All reasons** ☐

Reason(s) for Consult:

Coughing ☐ Choking ☐
Globus Sensation ☐
Odynophagia ☐ Recurrent PNA ☐
New onset PNA ☐ Poor PO intake ☐
Wt Loss ☐ SOB/Wheezing ☐
Wet Phonation ☐ Temp Spikes ☐
Suspect Silent Aspiration ☐
Diet Upgrade ☐ Diet Downgrade ☐
Other:_____

Previous: BSE ☐ **MBSS** ☐ **FEES** ☐
Results:_____
Date:_____

Dysphagia Onset: New ☐
Weeks ☐ Months ☐ Year(s) ☐

Vaccines: Flu ☐ PNA ☐ COVID ☐

Medical Necessity:

Dementia ☐ Alzheimer's ☐
CVA:_____
Cervical Spine:_____
Feeding Difficulties/Dysphagia ☐
GERD ☐ PNA ☐ COPD ☐
MR ☐ CP ☐ PD ☐ MS ☐
ALS ☐ HD ☐ MG ☐ Autism ☐
TBI/CHI:_____
Cancer:_____
Other:_____
_____

Respiratory Status

Room Air ☐ O2 ☐ _____L
Trach ☐ PMV ☐ Open Stoma ☐
Decannulation Date:_____
Vent ☐ HX of intubation ☐
History Smoker/Vape ☐
Current Smoker/Vape ☐
COVID-19 ☐ Date:_____

Dentition (upper and lower)

Natural U L Poor Dentition U L
Dentures U L Partials U L
Edentulous U L
Other:_____

Cognition (indicate EACH item)

Communicates Y N
Follows Commands Y N
Strategy-appropriate Y N

Speech Therapy None ☐

New Dysphagia Eval ☐
Oral/Motor Ex ☐
Hyolaryngeal/Pharyngeal Ex ☐
Cognition/Other ☐
Thermal Stim ☐
E-Stim – Ampcare ESP ☐
Vital Stim ☐

Other Important Info: **(please write legibly and provide any scheduling conflicts)**

ORDERING MD/DO/NP/PA Signature:_____ Date:_____ NPI:_____

Incomplete referrals will not be processed until all paperwork required is received. Verbal orders can be taken but a written order must be provided for ALL patients. If you have any questions, please call 817-514-6271.