DiagnosTEX
Consultants in Dysphagia Evaluation and Management

Information required to schedule with DiagnosTEX.
Phone: 817-514-MBS1 (6271) or 888-514-MBS1 (6271)
Fax: 817-514-MBS8 (6278) or 888-920-1201

All the information below must be received prior to a study being scheduled. Referrals can be emailed, via secure email to Katie@Diagnostex.us, Ashlea@Diagnostex.us or info@diagnostex.us, or faxed to one of the fax numbers above. Once all required information is received, the patient will be placed on our approved pending list to be scheduled. If you have any questions, please feel free to call us.

1. ***Order*** from the referring provider, if not signing the bottom of the consult request, must state one of the following to be a valid order for Diagnostex. Modified Barium Swallow Study, MBSS, or MBS. We cannot accept barium swallow study.
2. ***Face or Demographic sheet*** that has patients personal information including but not limited to, address, phone, insurance carrier with policy ID, POA if applicable, etc. A copy of the patient's insurance card(s) should also be included.
3. ***DiagnosTEX consult request*** history form (most current see attached.) Please note we have two consult forms, one for facility's i.e. nursing home, rehab hospital, or hospitals etc., and one for Home Health patients. These forms can all be found on our website at www.dysphagiadiagnostex.com.
4. ***History and physical (H&P)*** from speech therapist, referring MD, etc. For Home Health we require current 485.
5. ***DiagnosTEX authorization/consent form*** signed by patient or POA. Verbal for patients is allowed, if correctly completed on form.
6. ***Home Health Only*** – Signed DiagnosTEX Home Health acknowledgement form, including initials that are required on the form. If this form is not received prior to scheduling the patient, we will get this at the time of MBSS prior to starting the study.
7. ***Observation Consent Form*** this is only to be completed when a family member, POA, etc. is planning on attending the MBSS on our mobile clinic. ***PLEASE NOTE:*** Due to COVID-19 protocols we are still not allowing visitors on the van unless necessary for cooperation from the patient.
8. ***Facility Pay Form*** is used when the patient has an insurance that DiagnosTEX is not contracted with, a patient has Part A Medicare only, etc. This form must be received prior to scheduling the patient to be seen and signed by the administrator for that facility.

Please note DiagnosTEX runs our mobile clinics, Monday – Thursday (Friday only as needed). Our routes are based on geographic areas and the amount of referrals we have in that geographic area. ***We service the following counties: Dallas, Tarrant, Parker, Wise, Denton, Collin, and parts of Rockwall, Ellis, Johnson and Hood.*** For more information on the territory we cover please visit our website at www.dysphagiadiagnostex.com or please contact us at 817-514-6271

Thank you!

DiagnosTEX Staff

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.

DiagnosTEX
Consultants in Dysphagia Evaluation and Management

Observation Consent Form

Anyone who plans on observing the fluoroscopic procedure must sign the following consent. ABSOLUTELY NO EXCEPTIONS.

Name of patient: _____

Name of Visitor/Observer:_____Relationship to patient: _____
Is this visitor ☐treating healthcare staff ☐ Legal Guardian?
If not, treating healthcare staff or legal guardian, has the Legal Guardian or patient given consent to observe? Y N
If the answer is "NO", then due to HIPAA regulations, the visitor will be unable to attend the procedure.

Visitor/Observer must initial ALL statements and sign at the bottom of the page. Form must be presented to the DiagnosTEX staff a prior to entering the mobile clinic.

_____**1.** I am aware that there is absolutely no use of personal electronic devices on the mobile clinic. All video recording, pictures, or audio recordings are prohibited in all forms, on all devices, other than the medical equipment belonging to DiagnosTEX. I will comply with all DiagnosTEX policies and procedures and HIPAA regulations while on the mobile clinic. I agree that my personal phone or other electronic device must be turned off and placed inside a pocket or purse. The mobile clinic is private property/medical clinic and not public property. In the state of Texas, if any recording takes place on private property without the knowledge of the parties involved, this may be considered illegal and may be subject to legal action. *A copy of the medical procedure will be provided, on DVD, to the facility, home health, or health care professional requesting the procedure.*

_____**2.** This exam involves radiation exposure. A minimal amount of radiation scatter is a risk for all those present on the mobile clinic. I am aware of this exposure and accept full responsibility of any and all risks of being present during the procedure. Please take this into consideration if you are pregnant or may be pregnant.

_____**3.** The procedure is being dictated and recorded therefore there is no talking during the procedure except by those health care professionals conducting the examination and having direct patient contact. I will not interfere in the exam and I will only assist if asked to do so. I will be allowed to discuss the evaluation in detail wit the staff once the study and reports are completed.

_____**4.** If any of my personal items are left on the mobile clinic it will be my responsibility to retrieve this from DiagnosTEX. It is not the responsibility of DiagnosTEX to return any left items to me. DiagnosTEX will make sure any items are well taken care of and they will be left at the local office in Hurst, TX at the end of the day, for pick up during hours of operation.

_____**5.** Any and all medical records are the property of the facility or home health requesting the evaluation. Any extra copies of reports or a DVD can be obtained from the original document given to the facility/home health. Additional "release of records" paperwork can also be requested and completed with DiagnosTEX.

_____**6.** I understand that the medical team (MD, SLP, and/or technician) on the DiagnosTEX mobile clinic can ultimately determine if anyone is allowed on the mobile clinic, or must exit the mobile clinic during the exam if they are concerned that it may interfere with the staff, procedure and/or the patient in any way, despite the agreement to any of the above items.

_____7. I certify I have no active symptoms of a fever, cough, or other symptoms of a possible infection, nor I have been in contact with anyone with these symptoms in the last 14 days, or anyone currently diagnosed with a contagious illness (i.e. COVID-19, influenza, etc). Despite this, I agree to wear proper PPE per DiagnosTEX policies while in attendance of exam.

Signature _____ **Date:** _____

Original Signature only/no verbal consent. Must be presented at time of procedure with the visitor/observer

During 2020-2021 due to COVID-19 precautions, DiagnosTEX is not allowing nonessential observers on the clinic during the study unless necessary to complete the evaluation.

DiagnosTEX Home Health

Patient Authorization and Acknowledgement Form

ATTN: Patient/Family or Caregiver

Consultants in Dysphagia Evaluation and Management

Phone: 817-514-6271 **Fax: 817-514-6278**

Please thoroughly read the statements below and acknowledge understanding by initialing each line, signing and dating at the bottom of the page. Thank you.

1. **DiagnosTEX is a mobile clinic that will arrive at the home address to complete a Modified Barium Swallow Study inside the mobile clinic. A travel fee of $30.00 is due upon arrival or before arrival. _____(initials required)**

2. **All scheduled home health's must answer the phone to receive the estimated time of arrival and confirm the patient to be seen is there on the day of the study, prior to arrival. *******If there is no answer at the home, on our way to the location, the study will be cancelled for that day**************. _____ (initials required)**

3. **Patient, Family, and/or caregiver are aware that they will be required to exit their home to enter the mobile clinic. If the patient is not ambulatory, they must have their own wheelchair, and a ramp to exit the home. If this is not available, DiagnosTEX will not be able to perform the MBSS. Pt needs to be ready when mobile clinic arrives. _____(initials required)**

4. **The patient, family, and/or caregiver are aware that DiagnosTEX staff may be required to enter the home to evaluate the patient's medical status and/or form of transportation to the mobile clinic on site. DiagnosTEX staff will not enter the home unless someone is available to answer the door. _____ (initials required)**

5. **The patient should be up, dressed for appropriate weather conditions, and ready to be transported outside to the mobile clinic. DiagnosTEX staff is NOT responsible for transferring patients out of the bed into a wheelchair or transport from an upstairs location. _____ (initials required)**

6. **If DiagnosTEX arrives at the location of the patient and the patient does not answer the door, refuses to participate or unable to be transported to the mobile clinic for any safety reason, a flat fee of $175.00 will be charged for the medical staff's time and travel expenses to the location. _____ (initials required)**

Signature:_____ **Date**_____

Please return a signed copy of one and keep a copy for you own personal records.

DiagnosTEX Authorization/Consent Form (please read thoroughly)

Patient Name: _____ **Referring Healthcare provider:** _____

Contact information: _____

Patient or Responsible Party must *initial* all bulleted items and sign at the bottom of the page

All signatures must be obtained prior to the MBSS, please include all other required paperwork, this form alone does not initiate care.

I, _____, authorize to DiagnosTEX LLC and PLLC:

- _____To proceed with a Dysphagia Consultation including Modified Barium Swallow (MBS) study to determine the presence of dysphagia in the oral and pharyngeal stages as well as thoracic esophagus and cervical spine assessment. I acknowledge there is no guarantee as to the outcome of the results and recommendations. An untitled copy of the exam may be used for educational purposes in healthcare field.

- _____Authorization to use and disclose my medical information to bill and collect payment for services furnished to me by DiagnosTEX, LLC and/or PLLC. I hereby assign and transfer to DiagnosTEX, PLLC all rights, titles and interest benefits payable on all my insurance carriers. I authorize DiagnosTEX to initiate a complaint to the insurance Commissioner for any reason on my behalf.

- _____Authorize assignment of all medical benefits to which I am entitled, Medicare Part B, Medicaid or Other Private Insurance to DiagnosTEX, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

As the Responsible Party I, _____, agree to the following statements:

- _____It is my responsibility to pay any deductibles, co-pays or any other balance not paid by my insurance company.

- _____In the event insurance eligibility cannot be determined or denies payment; I am responsible for payment of all charges. DiagnosTEX, PLLC accepts cash, personal checks, money orders, credit cards and patient financing options.

- _____In the event my insurance company reimburses me in error, this payment will be forwarded to DiagnosTEX, PLLC.

- _____I have been informed of DiagnosTEX, LLC and PLLC HIPAA privacy notice and have also been informed that a copy is available to me on request. I consent to release my PHI, medical records and status pertaining to the Dysphagia Consultation, including radiological exams to the referring physician and referring clinician

- _____My referring/treating healthcare professional may temporarily access my patient portal on my behalf to obtain documentation on the diagnostic exam completed by DiagnosTEX.
  Email address of policy holder or POA _____ ☐NA

Patient's name (Print)_____

Signature of Policy Holder of Claimant_____ **Date:**_____

Witness signature required if individual is unable to sign independently

Witnesses must be employed by the facility. Preferably DON or administrative staff, if unavailable, nursing staff may sign

Witness:_____ Title:_____

****

If received verbal consent only, please document in medical chart and sign below

Consent received from_____ Date received: _____

Relationship to patient: ☐Patient ☐Guardian/POA ☐Health Care Proxy ☐_____

Staff Signature_____ Staff Title_____

Consultants in Dysphagia Evaluation and Management
817-514-MBS1 or 1-888-514-MBS1
Corp. Office
8913 Mid Cities Blvd.
Suite 100
North Richland Hills, Texas 76182

Private Pay Agreement

I have been informed and understand the procedure of the Modified Barium Swallow Study (MBSS). I authorize DiagnosTEX to complete the Modified Barium Swallow Study with Dysphagia Consultation on (patient name) _____

I agree to be billed the cost of this procedure, paid within 30 days at a discount of 50% for a total cost of $550.00, plus the travel fee of $30.00.

The travel fee ($30.00) and minimum of 1/3 of the payment ($200.00) is due up front.

A payment plan can be established with DiagnosTEX on any remaining balance. Please contact us at 817-514-6271 for more information.

_____	_____	_____
Signature	Relationship	Date
_____	_____	
Print name	Contact information	

MBSS study will not be scheduled until this paperwork is signed and returned to DiagnosTEX along with all other required paperwork.