Information required to schedule with DiagnosTEX

Phone: 1-888-514-MBS1 (6271) or 817-514-MBS1 (6271)

Fax ALL of the following items to 817-514-MBS8 (6278) or 1-877-514-MBS8 (6278):

1. Copy of the signed physician's order for "**Dysphagia Consultation including Modified Barium Swallow Study**" **or** a signature at the bottom of the DiagnosTEX Consult Request History form

2. Copy of the **Face sheet** from the patient's medical record

3. Completed **DiagnosTEX Consult Request History form** **(most current)**. If the patient is at a facility please fill out the **one for Facilities**, if the patient is a Home Health patient, please fill the **one for Home Health**. (If you do not have one please call and one will be faxed to you, or can be found on the website at www.dysphagiadiagnostex.com).

4. Due to EMR requirements, please print and fax the **most recent report of the History and Physical (H&P)** for the medical staff to review.

5. Signed **DiagnosTEX Authorization/Consent Form** (If you do not have one please call and one will be faxed to you, or can be found on the website at www.dysphagiadiagnostex.com)

6. **DiagnosTEX Observation Consent Form** – required for any visitor to observe MBSS – no exceptions

7. For Home Health Patients ONLY
   a. Signed **DiagnosTEX Home Health Acknowledgement Form** – initials ARE required. (If you do not have one please call and one will be faxed to you, or can be found on the website at www.dysphagiadiagnostex.com)

8. *Please provide a copy of Insurance and/or Medicare/Medicaid cards.*

All of the above information must be faxed to 817-514-6278 before the study will be scheduled for a day and time. Faxing all of these items will expedite scheduling. Once all of the required paperwork is received, the request for the MBSS will be placed on our pending list and will be scheduled as soon as possible.

If you have any questions about any of the above information please call 817-514-MBS1 (6271) or 1-888-514-MBS1 (6271). We value the opportunity to assist with the care of your patient.

DIAGNOSTEX Observation Consent Form

Anyone who is NOT a facility/HH healthcare professional 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 a Legal Guardian? Y N If no, has the Legal Guardian given consent to observe? Y N
If both questions are answered "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.

_____**3**. The procedure is being dictated and recorded therefore there is no talking during the procedure except by those health care professional 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.

_____**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 facility/home health. Additional "release of records" paperwork can also be completed with DiagnosTEX directly and it can be sent to me.

_____**6**. I understand that the medical team (MD, SLP, and/or technician) on the DiagnosTEX mobile clinic can 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.

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

Referral made to DiagnosTEX for Dysphagia Consultation including MBSS

Fax to DiagnosTEX at 817-514-6278 with Face sheet, Authorization Form and H & P

New Patient☐ Established Patient☐

Facility Info: Facility Name _____ **City**_____**Phone:** _____
Ordering MD: First _____ Last _____ **Scheduling Contact** _____Phone_____
Treating SLP: First_____ Last _____Phone _____ Text? yes ☐ no ☐

Patient Name _____ M F Age _____ DOB_____

Room # _____ **Ht** __ __**Wt** _____ Contact Precautions- Reason _____In isolation ☐
Ambulatory ☐ Walker ☐ Wheelchair ☐ XL Wheelchair ☐ Motorized wheelchair☐ Geri Chair ☐

Insurance Coverage - call main office 817-514-6271 for questions or assistance
Med A (skilled) ☐ Med B (non-skilled) ☐ Medicaid ☐ Hospice ☐ Other _____ Policy # _____

Reason Mobile/Onsite Visit is required: Physical condition negatively affected by transportation ☐ Fatigue level concerns and/or medically unstable ☐ Transportation would negatively affect behavior, cognition and fall risk ☐ All of the above ☐

Diet: Food Consistency _____ Liquid Consistency _____Trials _____ Strategies _____ NOMS __
NPO☐ - PEG/NG/Jtube AMA diet: _____ (requires signed ABN) Food Allergies* _____
*barium contains natural strawberry and citrus flavoring

Reason(s) for Consult
Coughing ☐ Choking ☐
Globus Sensation ☐ Odynophagia ☐
Recurrent PNA ☐ New Onset PNA ☐
Poor PO Intake ☐ Wt. Loss ☐
SOB/Wheezing ☐ Wet phonation☐
Suspect Silent Aspiration ☐
Temp Spikes ☐
Other _____
Diet Upgrade: _____
BSE recs_____
Previous MBSS _____
Rec _____
Other Instrumental Eval _____
Results_____

Medical Necessity (describe)
Eval☐ Improvement☐ Decline☐

Dysphagia Onset: New _____
wks ____ mos ____ yrs ____

Vaccine: Flu ☐ Date:_____ PNA☐

Medical History (check ALL that apply)
Alzheimer's/Dementia ☐
Cancer ☐ _____
Cervical Spine Surgery ☐_____
CVA ☐_____
CHF ☐ COPD ☐
Feeding Difficulties☐
GERD ☐ _____
MR☐ CP☐ Autism☐
PD☐ MS☐ ALS☐ HD☐
Pneumonia ☐ _____
TBI/CHI ☐_____
Other: _____
_____
_____
_____
_____

Respiratory Status Rm Air ☐
O2 ☐_____
Trach ☐ Speaking Valve ☐
Decannulation date _____
Open Stoma ☐
Vent ☐ Hx of Intubation ☐

Dentition (indicate 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 ☐
Cognition Only ☐
New Dysphagia Eval ☐
O – M Ex ☐
Hyolaryngeal / Pharyngeal Ex ☐
Thermal Stim ☐
Ampcare ESP™ ☐
Vital Stim™ ☐ Placement: _____

Other Important Infor: (Please write legibly)

This order is REQUIRED TO SCHEDULE. Please check and sign:

☒ Physician consult requests for dysphagia consultation to include all medically necessary assessment of swallowing, including Modified Barium Swallow Study (MBSS) and Esophageal Assessment

Cervical spine☐ VC assessment☐ Soft tissue☐ Limited chest view with any aspiration event☐

Ordering MD/NP/PA Signature _____ **Date** _____ **NPI** _____
Incomplete forms will not be processed until all paperwork required is complete Telephone or verbal order signed by DON or RN ONLY

DiagnosTEX Authorization/Consent Form

Please read thoroughly

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

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:**_____

All signatures must be obtained prior to the MBSS

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_____