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