

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.

HH/OP Referral made to DiagnosTEX for a Dysphagia Consult and MBSS

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

New Patient Established Patient

Patient informed of \$25 travel fee

Patient Name _____ M F Age ___ DOB _____ Ht ___ Wt ___

Location is a: private residence assisted living _____ or group home other _____

Ambulatory Walker Wheelchair XL Wheelchair Motorized wheelchair Geri Chair

Street address _____ Apt/Bldg/Unit _____ Gate code _____ City _____

Patient contact number _____ Other scheduling contact (if app) _____ Phone _____

HH Agency _____ Phone _____ Ordering MD: First _____ Last _____

Referring SLP: First _____ Last _____ Phone _____ Text? _____

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 Partial 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 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



DiagnosTEX Home Health Required Paperwork

Consultants in Dysphagia Evaluation and Management

Phone: 817-514-6271

Fax: 817-514-6278

Patient Authorization and Acknowledgement Form

ATTN: Patient/Family or Caregiver

Please thoroughly read the statements below and acknowledge 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 \$25.00 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. _____ (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 refuses to participate or unable to be transported to the mobile clinic for any reason, a flat fee of \$150.00 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 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 _____