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 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