

Name of Facility: _____ City: _____

Form Completed By: _____ Contact Cell #: _____

Facility Speech Path: _____ Facility Phone #: _____

Date: _____ Email Address: _____

Please CIRCLE One: Medicare A Medicare B Medicaid Policy # _____

Other Insurance: _____ Preauthorization # _____

Patient Name: _____ DOB: _____ Sex: M F

Referring Physician: _____ *(Please print first and last name)*

Reason for Consult: (CIRCLE those that apply)	<u>s/s of dysphagia</u>	<u>coughing</u>	<u>choking</u>	<u>difficulty swallowing</u>
<u>follow-up eval</u>	<u>determine least restrictive diet</u>	<u>determine safest diet</u>	<u>weight loss</u>	<u>pneumonia</u>
<u>diet upgrade</u>	<u>wet/gurgly phonation</u>	<u>pocketing/oral hold</u>	<u>suspect reflux</u>	<u>hx of GERD</u>
<u>feeding evaluation</u>	<u>suspect silent aspiration</u>	<u>breathing difficulty with food/liquid intake</u>	<u>pretx diagnostic evaluation of swallow</u>	

Has patient had a recent bedside swallowing evaluation? Y N Unknown if yes, date: _____

Has the patient had a recent change in status? Y N Unknown If yes, is the change for better or worse? (Circle one)

(CIRCLE all that apply) Does pt have PEG? Y N Duration of dysphagia symptoms: days weeks months years

Pertinent Medical History/Diagnosis (circle those that apply)

CVA Parkinson's GERD Alzheimer's Dementia CHF COPD Pneumonia Other: _____

What tx is being used? Oral motor estim thermal stim pharyngeal exercises none yet

Dentition: natural partials dentures edentulous

Current Diet: Regular Mech Soft Pureed NPO Liquids: regular/thin nectar honey pudding

Cognitive Status: Communicates: Y or N Follows one step commands: Y or N

Please check and sign this order (ORDER must be SIGNED BELOW to schedule)

- Include all of the below assessments in the comprehensive dysphagia consult including the modified barium swallow study (MBSS) - *this is the comprehensive evaluation we have always performed*
 - Esophageal scan - approx. 30% of our pts have asymptomatic esophageal dysphagia
 - Vocal cord assessment for structural integrity/abnormalities and function
 - Mandibular/dental assessment for structural integrity/abnormalities and function
 - Cervical spine assessment for structural integrity/abnormalities and function
 - Frontal chest view for aspiration when aspiration occurs
- Physician consult requested for dysphagia will include all medically necessary assessments of swallowing/deglutition

Date: _____

Primary Physician Signature (file in patient's permanent medical record for physician signature)

Signature of person verifying verbal order if physician is not available to sign above before scheduling

AUTHORIZATION

Verbal consent from patient or legal guardian for this procedure:

Date received: _____

Consent received from: _____

Staff Signature: _____