Fax to Professional Imaging: 1-877-676-6277 OR 281-272-6281

Phone: 1-866-675-6277

FAX IN THIS SIGNED FORM WITH FACE SHEET AND COPY OF INSURANCE INFO TO SCHEDULE STUDY

PEDIATRIC INTAKE FORM

Where to leave/send report: _____

Patient Phone #: _____ Patient's treating SLP:_____

Name of Parent or Guardian:_____

Date: _____ SLP Contact #:_____

Please CIRCLE One: Medicare Medicaid Other:_____ Preauthorization #_____

Patient Name: _____ DOB: _____ Age: _____ Sex: M F

Address where study to be done:_____ City: _____

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

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

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)

Cerebral Palsy TBI MR DD Syndrome(list name)_____ Other_____

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

Is Dentition age-appropriate? Y N Any food allergies? Y N If Yes, please list:_____

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

*have parent/guardian bring any special equipment needed for eating and drinking to best complete study

Cognitive Status: Communicates: **Y N** Follows one step commands: **Y 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:_____

May require advance beneficiary notice due to lack of insurance coverage, you will be notified prior to study