**NOTE: Patients must be able come OUTSIDE to the mobile clinic (van) to have study done with a walker, wheelchair, etc. We do not perform studies bedside or inside the home. We DO have a wheelchair lift on our mobile clinic (van).**

# Home Health Intake

**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**

**Form Completed By:**_____ **Patient Phone/Cell #:** _____

**Facility Speech Path:**_____ **SLP Cell #:**_____

**Date:**_____ **Where to fax/email study:**_____

**Please CIRCLE One:** Medicare Medicaid Other_____Preauthorization #_____

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

**Address of where patient to be seen:**_____ **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)

*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:_____

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