

Name of Facility: _____

City: _____

Facility Speech Path: _____ Contact Cell #: _____

Facility Phone #: _____ Date: _____ Email: _____

Please CIRCLE One: Skilled Stay Not Skilled Name of Primary Insurance: _____

Patient Name: _____ DOB: _____ Sex: M F

Ordering Physician (first and last name, please print clearly): _____

Primary Reason for Consult, s/s of dysphagia: (CIRCLE those that apply/listed in alphabetical order): breathing difficulty with po intakebreathy vocal sound coughing choking dehydration difficulty swallowing dizziness feeding difficultiesfood/pills getting stuck GERD/Esophageal reflux globus sensation heartburn hoarse vocal quality malnutritionmoist cough pneumonia pocketing poor po intake recurrent pneumonia respiratory distress shortness of breathspitting food/saliva suspect silent aspiration tearing with oral intake vomiting weightloss wet vocal quality wheezing with po**Other indications for swallowing evaluation:** determine least restrictive diet determine safest diet improvement with swallowingdecline with swallowing feeding evaluation pre-tx evaluation of swallow suspect reflux

Has patient had a recent bedside? Yes No Pt is in favor of pursuing PEG if recommended: Yes No Unknown

Pt's swallow function has recently: improved declined unchanged Does pt have PEG? Yes NoDuration of dysphagia symptoms: days weeks months years Frequency of symptoms: w/ all po liquids solids saliva**Pertinent Medical History/Diagnosis** (circle those that apply) Pt has had study with Professional Imaging before: Y N UnknownCVA Parkinson's GERD Alzheimer's Dementia CHF COPD Pneumonia Other: _____What tx is being used? Oral/pharyngeal exercises estim thermal stim none yet-awaiting physiologic evaluationDentition: natural partials dentures edentulous Cognition: Communicates: Y or N Follows commands: Y or NCurrent Diet: Regular Mech Soft Pureed NPO Liquids: regular/thin nectar honey pudding**Check and Sign Order**

- ☐ Include all of the below conditional assessments, if medically indicated, as part of a dysphagia consultation including the modified barium swallow study (MBSS) - comprehensive consult for medically complex patients
- Esophageal scan - approx. 30% of pts have asymptomatic esophageal dysphagia, view esophageal emptying into stomach
 - Vocal cord assessment- for closure to protect against aspiration
 - Mandibular/dental assessment for structural integrity/abnormalities and function for chewing/muscular support to evaluate risk for choking with solids to determine appropriate diet level
 - Cervical spine/soft tissue assessment for structural integrity/abnormalities and function, changes can lead to redirection of bolus increasing risk for aspiration and requiring a different level of strategy use
 - Frontal chest view for aspiration when aspiration occurs-allows for a risk stratification for aspiration pneumonia
 - Physician consult requested for dysphagia – impact of PO intake on prognosis, impact of medication and anatomy; quality of life and rehab candidacy discussion, recommendations for further consult

OR – Write individual component(s) here:

*order guidelines at mbssonline.com for further explanation

→ Mobile/onsite visit requested by Doctor due to (please circle) or write in answer here: _____

- emergent request due to elevated aspiration risk • transport negatively impacts underlying physical condition
- fatigues easily, compromising test participation • transport exacerbates behavioral problems and compromising test participation

→ Signature: _____ → Signature: _____

Sign HERE-Verbal order and Consent verification signature- _____ PHYSICIAN OR NP/ PA SIGNATURE (FILE IN CHART TO SIGN)**AUTHORIZATION**

Verbal consent from patient or legal guardian for this procedure:

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

→ Does responsible party agree to study? Y or N