

Home Health Intake: Fax to Professional Imaging: 1-877-676-6277 or 281-272-6281

Phone: 1-866-675-6277 **REQUIRED DOCUMENTS TO SCHEDULE STUDY: SIGNED INTAKE, FACE SHEET, COPY OF INSURANCE**

Pts MUST be able to come outside to the mobile clinic for the study by walker or wheelchair, we do have a lift, we do not perform studies inside a home at the bedside. If available: Send Bedside Documentation

Address of where pt to be seen: _____

City: _____ 9-digit Zip Code: _____ Special Instructions: _____

Form completed by: _____ Contact # of person completing form: _____

Patient home/cell phone #: _____ Date: _____ fax /email report to: _____

Name of Primary Insurance: _____ Member ID: _____

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 intake

breathy vocal sound coughing choking dehydration difficulty swallowing dizziness feeding difficulties

food/pills getting stuck GERD/Esoophageal reflux globus sensation heartburn hoarse vocal quality malnutrition

moist cough pneumonia pocketing poor po intake recurrent pnemonia respiratory distress shortness of breath

spitting 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 swallowing

decline 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 No

Duration 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 Unknown

CVA 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 evaluation

Dentition: natural partials dentures edentulous Cognition: Communicates: Y or N Follows commands: Y or N

Current 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