Professional Imaging, LLC

Consultants in Dysphagia Diagnosis and Management

FAX #: 1-877-676-6277 OR 281-272-6281

Phone: 1-866-675-6277

FAX IN THIS FORM WITH FACE SHEET TO SCHEDULE STUDY
FILE IN CHART FOR PHYSICIAN REVIEW

INTAKE

Form Completed By:_____ **Facility Phone #:** _____
Facility Speech Path:_____ **Contact Cell #:**_____
Date:_____ **Email Address:**_____

_____VHS Tape _____DVD

Please CIRCLE One: Medicare A Medicare B Medicaid

Other_____ Preauthorization #_____

Patient Name: _____ **DOB:** _____ **Age:** _____

Facility:_____ **City:** _____

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

Reason for Consult: s/s of dysphagia: ____**Coughing** ____**Choking** ____**difficulty swallowing**

___**weight loss**___**pneumonia**___**respiratory Distress**___**wet/gurgly phonation**___**pocketing**___**diet upgrade**

___**pre-treatment diagnostic evaluation of swallow, high risk diagnosis**

Does pt have PEG? ___Yes ___No Duration of dysphagia symptoms: ___days ___weeks ___months ___years

Pertinent Medical History/Diagnosis **(check those that apply)**
___*CVA* ___*Parkinson's Dz* ____ *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 ____endentulous

Current Diet: ___Regular ___Mech Soft ___Pureed ___NPO **Liquids**: ___regular ___nectar ___honey ___pudding

Cognitive Status: _____Communicates _____Follows one step commands

ORDER

Upon faxing this document to Professional Imaging, it is indicated that the facility has obtained a request from the referring physician listed above for a dysphagia consultation including the MBSS. This request is in the patient's medical record for signature by the physician.

AUTHORIZATION

Verbal consent from patient or legal guardian for this procedure. Please document in medical chart and sign below:
Date received:_____
Consent received from:_____
Staff Signature:_____