

REQUIRED DOCUMENTS TO SCHEDULE STUDY: FAX IN THIS SIGNED FORM OR ORDER WITH FACE SHEET IF AVAILABLE: FAX BEDSIDE EVALUATION

Name of Facility: \_\_\_\_\_ City: \_\_\_\_\_

Form Completed By: \_\_\_\_\_ Contact Cell #: \_\_\_\_\_

Facility Speech Path: \_\_\_\_\_ Facility Phone #: \_\_\_\_\_

Date: \_\_\_\_\_ Email Address: \_\_\_\_\_

Please CIRCLE One: Medicare A Medicare B Medicaid Policy # \_\_\_\_\_

Other Insurance: \_\_\_\_\_ Preauth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F

Referring Physician: \_\_\_\_\_ (print first and last name)

**Primary Reason for Consult:** (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/Esophageal reflux globus sensation heartburn hoarse vocal quality malnutrition moist cough pneumonia  
pocketing poor po intake recurrent pneumonia respiratory distress shortness of breath signs/symptoms of dysphagia  
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 diet upgrade determine safest diet  
improvement with swallowing decline with swallowing feeding evaluation pre-tx evaluation of swallow suspect reflux

Has patient had a recent bedside swallowing evaluation? Y N Unknown if yes, please fax with this form

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: \_\_\_\_\_