

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 Louisiana Dysphagia Consultants at: **1-877-787-9377**

FAX IN THIS SIGNED FORM WITH FACE SHEET AND COPY OF INSURANCE INFO TO SCHEDULE STUDY

Phone: 225-308-9846 Date: _____ Where to fax/email study: _____

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

Facility Speech Path: _____ SLP Cell #: _____

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)*

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 pnemonia 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, 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