

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

PEDIATRIC INTAKE FORM

Where to leave/send report: _____

Patient Phone #: _____ Patient's treating SLP: _____

Name of Parent or Guardian: _____

Date: _____ SLP Contact #: _____

Please CIRCLE One: Medicare Medicaid Other: _____ Preauthorization # _____

Patient Name: _____ DOB: _____ Age: _____ Sex: M F

Address where study to be done: _____ 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)

Cerebral Palsy TBI MR DD Syndrome(list name) _____ Other _____

What tx is being used? Oral motor estim thermal stim pharyngeal exercises none yet

Is Dentition age-appropriate? Y N Any food allergies? Y N If Yes, please list: _____

Current Diet: Regular Mech Soft Pureed NPO Liquids: regular/thin nectar honey pudding

*have parent/guardian bring any special equipment needed for eating and drinking to best complete study

Cognitive Status: Communicates: Y N Follows one step commands: Y 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

Primary Physician Signature (file in patient's permanent medical record for physician signature) Date: _____

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 insurance coverage, you will be notified prior to study