Pediatric 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 (include 9-digit zip):_____

City: _____ **Parent Name:**_____***have parent/guardian bring any special equipment needed for study**

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/Esophageal 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

Cerebral Palsy *TBI* *MR* *DD* *Syndrome (List name)*_____ *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 evalulate 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: → Does responsible party agree to study? Y or N

May require advance beneficiary notice due to lack of Medicare coverage, you will be notified prior to study

REV 07/12