

For DTEX office use:  
 new  
 established

# Referral Made to **DiagnosTEX** for Dysphagia Consultation, including MBSS **FACILITY FORM**

Once completed Fax to DiagnosTEX at 817-514-6278 with **FACE SHEET, AUTHORIZATION FORM and H & P**

**Facility Contact Information:** Name \_\_\_\_\_ Address \_\_\_\_\_  
Ordering MD: First \_\_\_\_\_ Last \_\_\_\_\_ Scheduling Contact \_\_\_\_\_ Phone \_\_\_\_\_  
Treating SLP \_\_\_\_\_ Phone \_\_\_\_\_ Text? yes  no

**Patient Name** \_\_\_\_\_ **M** **F** **Age** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Room #** \_\_\_\_\_ **Ht** \_\_\_\_\_ **Wt** \_\_\_\_\_  
Wheelchair  XL Wheelchair  Geri Chair  Walker  Ambulatory  Contact Precautions? yes  no

**Insurance Coverage** - call main office 817-514-6271 for questions or assistance

Med A (skilled)  Med B (non-skilled)  Medicaid  Hospice  Other \_\_\_\_\_ Policy # \_\_\_\_\_

**Reason Mobile/Onsite Visit is Required:**

Physical condition negatively affected by transportation  Fatigue level concerns and/or medically unstable   
Transportation would negatively affect behavior, cognition and fall risk  All of the above

**Current Diet:** Food Consistency \_\_\_\_\_ Liquid Consistency \_\_\_\_\_ Trials \_\_\_\_\_ Strategies \_\_\_\_\_  
NOMS \_\_\_\_\_ NPO - PEG/NG/Jtube \_\_\_\_\_ AMA diet: \_\_\_\_\_ (requires signed ABN) Food Allergies\* \_\_\_\_\_

\*barium contains natural strawberry and citrus flavoring

**Reason(s) for Consult**

Coughing   
Choking   
Dehydration   
Globus Sensation   
Odynohagia   
Recurrent Pneumonia   
New Onset of Pneumonia   
Poor PO Intake   
SOB/Wheezing   
Suspect Silent Aspiration   
Temp Spikes   
Wet Phonation   
Weight Loss   
Suspect Silent Aspiration   
Upgrade Diet: \_\_\_\_\_

**Recent BSE** \_\_\_\_\_

**Recent MBSS** \_\_\_\_\_  
Results \_\_\_\_\_

**Medical Necessity** (describe)

Improvement \_\_\_\_\_  
Decline \_\_\_\_\_  
Current Status \_\_\_\_\_

**Dysphagia Onset:** New \_\_\_\_\_  
wks \_\_\_\_\_ mos \_\_\_\_\_ yrs \_\_\_\_\_

**Medical History** (check all that apply)

Alzheimer's   
Cancer  \_\_\_\_\_  
Cervical Spine Surgery   
CVA   
CHF   
COPD   
Dementia   
Feeding Difficulties   
GERD   
MR   
MS   
Parkinson's   
Pneumonia  \_\_\_\_\_  
TBI/CHI   
Other: \_\_\_\_\_  
Flu Vaccine  Date: \_\_\_\_\_  
Recent Pneumonia Vaccine

**Respiratory Status**

WFL   
O2   
Trach   
Speaking Valve   
Vent   
Open Stoma   
Hx of Intubation

**Dentition** (indicate upper and lower)

Natural U L  
Dentures U L  
Edentulous U L  
Partials U L  
Poor Dentition U L  
Other: \_\_\_\_\_

**Cognition** (indicate EACH item)

Communicates Y N  
Follows commands Y N  
Strategy-appropriate Y N

**Speech Therapy**

None   
Cognition Only   
New Dysphagia Eval   
O - M Ex   
Hyolaryngeal / Pharyngeal Ex   
Thermal Stim   
ESP™   
Vital Stim™  Placement: \_\_\_\_\_

**Other Important Information:**

(Please write legibly)

**This order is REQUIRED TO SCHEDULE. Please check and sign:**

- Physician consult requests for dysphagia consultation to include all medically necessary assessment of swallowing, including Modified Barium Swallow Study (MBSS) and Esophageal Assessment  
 cervical spine  vocal cord assessment  soft tissue  limited chest views with any aspiration events

**Ordering MD/NP/PA Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **NPI** \_\_\_\_\_

Telephone or verbal order signed by DON or RN ONLY