For DTEX office use:
☐ new
☐ established

Referral Made to DiagnosTEX for Dysphagia Consultation, including MBSS

HOME HEALTH/OUTPATIENT

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

Scheduling Contact Information: **Name** _____ **Relation to Patient** _____
Ordering MD: First _____ Last _____ Phone _____
Referring SLP _____ Phone _____ Fax _____ Agency _____

Patient Name _____ M F Age _____ DOB _____ Room # _____ Ht __ Wt __

Patient can consent to consultation for themselves ☐ OR healthcare proxy has been invoked ☐
Exam to be scheduled at: private residence ☐ assisted living ☐ dayhab ☐ group home ☐ other ☐ _____
Street address _____ Apt/Bldg/Unit _____ Gate code_____ City_____
Patient informed of $25 travel fee ☐

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