Pediatric Home Health Intake Form for Professional Imaging Mobile Dysphagia Consult

FAX to: 281-272-6281 or 1-877-676-6277 Required documents to schedule study: intake/correct order, face sheet with insurance information Phone #: 1-866-675-6277 **Scheduling may be delayed if 1-8 are not completed.** **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 at the bedside.**

1. Address of where pt to be seen: ____

City:________________________ **9-digit Zip Code:**______________ **Special Instructions:**________________________

Person completing form : ______________________________ **Contact # of person completing form:**________________

Patient home/cell phone #: ____________________________ **Date:** ____________ **Fax/email report to:** ____________

Check: ☐ **Medicare** ☐ **Medicaid** ☐ **Primary Insurance Name:**_________________ #_______________

Patient Name:______________________________ **DOB:** ________________ **Sex: M or F Height:**_______ **Weight:**____

2. Ordering Physician (first/last name required):____

3. SYMPTOMS, primary medical reasons for consult (required): coughing coughing with po choking difficulty swallowing feeding difficulty risk of aspiration risk of silent aspiration breathing difficulty with po breathy vocal sounds food/pills getting stuck GERD/Esophageal reflux hoarse vocal quality malnutrition/ dehydration moist cough nausea pneumonia pocketing poor po intake recurrent pneumonia reflux respiratory distress runny nose shortness of breath spitting food/saliva tearing with oral intake vomiting weightloss wet vocal quality wheezing with po

4. Status Change due to : improvement decline weight loss malnutrition pneumonia reduced po

New onset of: increased awareness decreased awareness choking coughing pocketing poor po

Patient swallowing status: BETTER (risk for silent aspiration and/or symptoms above) or **WORSE (see symptoms above)**

Other goals: find safest/least restrictive diet diet upgrade pre-TX feeding eval **Dentition:** natural poor dentures edentulous

Current diet: Regular Mech Soft Puree NPO **Current Liquids:** Regular Nectar Honey Pudding NPO

Duration of symptoms: days weeks months years unknown **Frequency of symptoms**: all po liquids solids pills saliva

Does patient currently have PEG? Yes or No **Communicates**: Y or N **Follows commands:** Y or N

Pertinent Medical History/Diagnosis (Required): Cerebral Palsy TBI MR DD Syndrome (List):_______________
Other______________________________________

Current Treatment? Oral/pharyngeal exercises e-stim thermal stim none at this time unknown

Recent Bedside? Y or N **Pt in favor of PEG if suggested**: Yes No Unknown

5. CHECK ORDER PORTION-REQUIRED*

☐ **Include all of the below conditional assessments, if medically indicated, as part of a dysphagia consultation including the 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 evaluate 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 of 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: *see guidelines at proimagetx.com for further explanation: ________________________________

6. Check Reason(s) Mobile/Onsite Visit is Required:

☐ emergent request due to elevated aspiration risk ☐ transport negatively impacts underlying physical condition

☐ fatigues easily, compromising test participation ☐ transport exacerbates behavioral problems and compromises test participation

7. Signature REQUIRED:X____________________________ **RN LVN SLP** Physician Signature: _______________

NURSE OR SLP TO SIGN AND CIRCLE CREDENTIALS TO VERIFY VERBAL ORDER (file in chart for physician to sign)

8. Consent (circle) Verbal consent received from patient/legal guardian? ***Yes*** or ***No***

****have guardian bring special equipment if needed for study**