**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**

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