

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 Hospice 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): Alzheimer's CVA CHF HTN CAD Dementia DM Dysphagia
Parkinson's GERD COPD Hip Fx Pneumonia PEG CA 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
 requires supervision and special transport 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)