Facility 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.****

1. **Facility Name:** _____ **City:**_____ **Phone:** _____

Person completing form : _____ **Direct contact cell (we text):** _____

Check: ☐**Skilled** ☐**Not skilled** ☐**Medicaid** ☐**Hospice** ☐**Primary insurance name:**_____ #_____

Patient Name:_____ **DOB:** _____ **Sex: M or F Height:**_____ **Weight:**_____

2. **Ordering Physician (first/last name required):**_____ **Date:** _____

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)

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

*May require advance beneficiary notice due to lack of Medicare coverage, you will be notified prior to study

Rev 11/4/15