

Mobile Dysphagia Consultation Order Form

(For Skilled Nursing Facilities & Hospital Settings)

Once Completed – Fax to MassTex Imaging at 978.279.1066 with **FACE SHEET** and **H&P**



(1) FACILITY CONTACT INFORMATION

Facility Name _____ City _____ State _____ Phone _____ Ext _____
Scheduling Contact _____ Department _____ Phone _____ Ext _____
Treating SLP/OT _____ Contact Number _____ Text _____ Yes _____ No

(2) PATIENT DEMOGRAPHICS

Name _____
DOB _____ Sex _____
Height _____ Weight _____
SS # _____
Room/Unit # _____

(3) VERBAL CONSENT

Verbal Consent Obtained From

___ Patient
___ HCP Name _____

Verbal Consent Received By

Staff Printed Name _____
Staff Signature _____

(4) INSURANCE INFO

Skilled Stay _____ Yes _____ No _____
___ Medicare A _____ Medicare B _____
Medicare # _____
Other Policy _____
___ Medicaid – Indicate State _____
Medicaid # _____

(5a) **ORDERING PHYSICIAN** *NAME REQUIRED* First _____ Last _____
(PRINT LEGIBLY)

(5b) PHYSICIAN ORDER Dysphagia Consultation Including MBSS and Esophageal Assessment to Stomach

Ordering MD/NP/PA Signature _____ Date _____ NPI _____
Electronic Orders & Signed Orders on Facility Forms are also Accepted

Printed Name of Signing Party *If different from section 5a* First _____ Last _____

(5c) **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

(6) MEDICAL HISTORY

(Check all that apply)

Diagnosis

___ CVA
___ CHF
___ COPD
___ Developmental Delays
___ Intellectual Impairment
___ Parkinson's
___ GERD
___ Alzheimer's
___ Dementia
___ Pneumonia
___ TBI/CHI
___ Head/neck cancer
___ Other _____

Respiratory Status

___ WFL
___ O-2
___ Trach Type _____ Size _____
___ Vent
___ Speaking valve

CONTACT PRECAUTIONS _____ Yes _____ No

If yes, reason _____

Food Allergies _____ Yes _____ No

If yes, list _____

(7) MEDICAL NECESSITY FOR CONSULT

(Check all that apply)

___ Breathing difficulty w/ PO intake ___ Pain on swallowing
___ Coughing ___ Pneumonia
___ Choking ___ Poor PO intake
___ Dehydration ___ Respiratory distress
___ Feeding Difficulties ___ Shortness of breath
___ Food/pills getting stuck ___ S/S of silent aspiration
___ Gagging ___ Tearing with oral intake
___ Esophageal reflux ___ Vomiting
___ Globus sensation ___ Weight loss
___ Heartburn ___ Wet vocal quality
___ Malnutrition ___ Wheezing with PO intake
___ Moist cough ___ Other _____

Duration of Symptoms

___ New Onset

___ Days

___ Weeks

___ Months

Other Goals

___ Determine least restrictive diet
___ Determine safest diet
___ Pre-treatment evaluation
___ Determine appropriate swallow maneuvers/strategies

Frequency of Symptoms

___ All PO
___ Liquids
___ Solids
___ Pills
___ Saliva
___ Other _____

Status Change Due To

___ Weight loss
___ Malnutrition
___ Pneumonia
___ Reduced PO
___ Increased awareness
___ Decreased awareness
___ Improved swallowing
___ Decline in swallowing

(8) SWALLOWING TREATMENT

___ Not on caseload for dysphagia
___ New Evaluation
___ E-Stim
___ Thermal Stim
___ O-M ex.
___ Pharyngeal ex.

Candidate for Strategies _____ Yes _____ No

(9) CURRENT DIET

___ NPO
___ Gtube ___ Jtube ___ NGT
Solids _____
Liquids _____
Trials _____
Current Strategies: _____

(10) SCHEDULING RESTRICTIONS