Mobile Dysphagia Consultation Order Form

(For Outpatient, Home Care, Assisted Livings, Dayhabs, Group Homes & Physician Offices)

Once Completed – Fax to MassTex Imaging at 978.279.1066 with FACE SHEET, CONSENT, MED LIST and H&P

MASSTEX IMAGING

(1) EXAM TO BE SCHEDULED AT

____Private Residence ____Assisted Living ____Group Home ____Day Hab Facility Name (if applicable)_____

Street Address_____ Apt/Bldg/Unit_____ City_____ State_____

(2) SCHEDULING CONTACT

(For preliminary arrangements and day of exam contact)

Name_____ Relation to Patient_____

Primary Contact #_____ Secondary #_____

(3) INSURANCE INFORMATION

___Medicare A ___Medicare B Medicare #_____

___Medicaid – Indicate State_____ Medicaid #_____

___Other Policy_____

(4) PATIENT DEMOGRAPHICS

Name _____

DOB _____ Sex_____

Height _____ Weight_____

SS # _____

Can Patient Consent for Self ____Yes ____No

Health Care Proxy Invoked ____Yes ____No

(5) TREATING SLP/OT/RN

Name_____

Cell #_____ Text ___Yes ___No

Best Contact #_____

Email_____

Agency_____

Address_____

_____

(6a) ORDERING PHYSICIAN

NAME REQUIRED (PRINT LEGIBLY)

First Name _____

Last Name_____

Practice Name_____

Address_____

_____

Phone # _____

(6b) *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 6a*** First_____ Last_____

(6c) 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) MEDICAL HISTORY

(Check all that apply)

Diagnosis

___CVA
___COPD
___TBI/CHI
___Dementia
___Intellectual Impairment
___CHF
___GERD
___Parkinson's
___Pneumonia
___Head/neck cancer

___Other_____

___Yes ___No: Covid-19 Past 30 Days
___Yes ___No: DNR
___Yes ___No: Incontinent

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

(8) MEDICAL NECESSITY FOR CONSULT

(Check all that apply)

___Breathing difficulty w/ PO intake
___Coughing
___Choking
___Dehydration
___Feeding Difficulties
___Food/pills getting stuck
___Gagging
___Esophageal reflux
___Globus sensation
___Heartburn
___Malnutrition
___Moist cough
___Pain on swallowing
___Pneumonia
___Poor PO intake
___Respiratory distress
___Shortness of breath
___S/S of silent aspiration
___Tearing with oral intake
___Vomiting
___Weight loss
___Wet vocal quality
___Wheezing with PO intake
___Other_____

Duration of Symptoms

___New Onset
___Days
___Weeks
___Months

Frequency of Symptoms

___All PO
___Liquids
___Solids
___Pills
___Saliva
___Other_____

Other Goals

___Determine least restrictive diet
___Determine safest diet
___Pre-treatment evaluation
___Determine appropriate swallow maneuvers/strategies

Status Change Due To

___Weight loss
___Malnutrition
___Pneumonia
___Reduced PO
___Increased awareness
___Decreased awareness
___Improved swallowing
___Decline in swallowing

(9) SWALLOWING TREATMENT

___Not on caseload for dysphagia
___New Evaluation
___E-Stim
___Thermal Stim
___O-M ex.
___Pharyngeal ex.

Candidate for Strategies ____Yes ____No

(10) CURRENT DIET

___NPO
___Gtube ___Jtube ___NGT

*Solids*_____

*Liquids*_____

*Trials*_____

Current Strategies:

(11) SCHEDULING RESTRICTIONS