Mobile Dysphagia Consultation Order Form

(For Skilled Nursing Facilities & Hospital Settings)

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

MASSTEX IMAGING

(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
___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

(7) 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/GERD
___Globus sensation
___Heartburn
___Malnutrition
___Moist cough
___Pain on swallowing
___Pneumonia
___Poor PO intake
___Respiratory distress
___Shortness of breath
___Suspect silent aspiration
___Tearing with oral intake
___Vomiting
___Weight loss
___Wet vocal quality
___Wheezing with PO intake
___Other_____

Duration of Symptoms

___Recent Onset

___Weeks

___Months

___Years

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

(8) SWALLOWING TREATMENT

___Not on caseload for dysphagia
___New Evaluation
___E-Stim/NMES
___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