Referral made to LA Imaging Clinic for Dysphagia Consultation including MBSS

Submit to LA Imaging (Fax 888-463-0982) and include Face sheet and H & P

New Patient☐ Established Patient☐

Facility Info: Facility Name _____ **City**_____ **Phone:** _____
Ordering MD: First_____Last_____**Scheduling Contact**_____Phone_____
Treating SLP: First_____Last_____ Phone_____Text? yes ☐ no ☐

Patient Name _____ M F Age_____DOB _____

Room #_____ **Ht**__ __**Wt**____ Contact Precautions- Reason_____In isolation ☐

Ambulatory ☐ Walker ☐ Wheelchair(WC) ☐ XL WC ☐ Motorized WC☐ Geri Chair ☐ Patient email: _____

Insurance Coverage - call main office 318-473-1978 for questions or assistance Insurance_____Policy # _____
Med A (skilled) ☐ Med B (non-skilled) ☐ Medicaid ☐ Hospice ☐ Hospice dx _____

Diet: Food Consistency_____Liquid Consistency_____Trials_____ Strategies_____NOMS ____
NPO☐ - PEG/NG/Jtube AMA diet:_____(requires signed ABN) Food Allergies* _____
*barium contains natural strawberry and citrus flavoring

Reason(s) for Consult
Coughing ☐ Choking ☐
Globus Sensation ☐ Odynophagia ☐
Recurrent PNA ☐ New Onset PNA ☐
Poor PO Intake ☐ Wt. Loss ☐
SOB/Wheezing ☐ Wet phonation☐
Suspect Silent Aspiration ☐
Temp Spikes ☐
Other_____
Diet Upgrade: _____
BSE recs_____
FEES rec_____
Previous MBSS _____
Rec _____

Medical Necessity (describe)
Eval☐ Improvement☐ Decline☐

Dysphagia Onset: New _____
wks____mos____yrs ____

Vaccine: Flu ☐ Date:_____PNA☐
COVID19+ HX ☐ Current ☐
Date Negative test _____

Medical History (check ALL that apply)
Alzheimer's/Dementia ☐
Cancer ☐ _____
Cervical Spine Surgery ☐_____
CVA ☐_____
CHF ☐ COPD ☐
Feeding Difficulties/Dysphagia☐
GERD ☐ _____
MR☐ CP☐ Autism☐
PD☐ MS☐ ALS☐ HD☐ MG ☐
Pneumonia ☐ _____
TBI/CHI ☐_____
Other: _____
_____
_____
_____

Respiratory Status Rm Air ☐
O2 ☐_____L Smoker/Vaping☐
Trach ☐ Speaking Valve ☐
Decannulation date _____
Open Stoma ☐
Vent ☐ Hx of Intubation ☐

Dentition (indicate upper and lower)
Natural U L Poor Dentition U L
Dentures U L Partials U L
Edentulous U L
Other: _____

Cognition (indicate EACH item)
Communicates Y N
Follows commands Y N
Strategy-appropriate Y N

Speech Therapy None ☐
Cognition Only ☐
New Dysphagia Eval ☐
O - M Ex ☐
Hyolaryngeal / Pharyngeal Ex ☐
Thermal Stim ☐
Ampcare ESP™ ☐
Vital Stim™ ☐ Placement: _____

Other Important Infor: (Please write legibly)

This order is REQUIRED TO SCHEDULE. Please check and sign:

Reason Mobile/Onsite Visit is required: Physical condition negatively affected by transportation ☐ Fatigue level concerns and/or medically unstable ☐ Transportation would negatively affect behavior, cognition and fall risk ☐ **All reasons ☐**

☒Physician consult requests for dysphagia consultation to include all medically necessary assessment of swallowing, including Modified Barium Swallow Study (MBSS) and Esophageal Assessment
Cervical spine (1-2 views)☐ VC assessment☐ Soft tissue☐ Limited chest view (1 view) with any aspiration event☐

Ordering MD/NP/PA Signature_____**Date**_____**NPI** _____
Incomplete forms will not be processed until all paperwork required is complete Telephone or verbal order signed by DON or RN ONLY