HH/OP Referral made to LA Imaging Clinic for a Dysphagia Consult and MBSS

Fax to LA Imaging at 888-463-0982 with Face sheet and H & P

New Patient☐ Established Patient☐ **Patient informed of $30 travel fee ☐**

Patient Name ______________________ **M F Age___ DOB**_________ Ht__ Wt______ lbs

Location is a: Private residence ☐ Assisted living☐ ____________________ or Group home ☐ other☐ ___________________

Ambulatory ☐ Walker ☐ Wheelchair ☐ XL Wheelchair ☐ Motorized wheelchair☐ Geri Chair ☐

Street address________________________ Apt/Bldg/Unit_________ Gate code_______ City____________

Patient contact number_____________________ Other scheduling contact (if app)__________________ Phone ___________

Ordering MD: First__________ Last__________ HH Agency________________ Phone____________

Referring SLP: First__________ Last__________ Phone______________ Text = Y/N FAX ____________

Insurance Coverage - call main office 318-473-1978 for questions or assistance Insurance______________ Policy # ___________

Hospice ☐ Hospice dx____________________ Pt Email: _______________________________

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 recs ___________________
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☐
Pneumonia ☐ ________________
TBI/CHI ☐________________
Other: ____________________
____
____
____
____

Respiratory Status Rm Air ☐
O2 ☐_____L Smoking/ 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 listed ☐**

☒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☐ All views☐

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