PatheousHealth

FAX COVERSHEET / PATIENT REFERRAL FORM

☐ **IL / IN / MI / WI referrals:**
TO: Scheduling Office
PHONE: 1-800-552-6103 or 1-913-359-6001
FAX: 1-913-359-5552
EMAIL: pdavis@patheoushealth.com

☐ **OH / PA referrals:**
TO: Scheduling Office
PHONE: 1-888-225-9227 or 1-330-923-3502
FAX: 1-330-923-3507
EMAIL: ohiosched@patheoushealth.com

FROM: ____
PHONE: ____________________ **FAX:** ______________________
DON: ____________________ **ADM:** ______________________ **SLP:** ______________________
CELL: ______________________

 # PAGES INCLUDING THIS COVER SHEET: ____
Patient name: ______________________________ **Code status**: ______________________________
DOB: ______________________________ **Date of last flu shot:** ______________________________
Ordering Physician:______________________________ **NPI# (Required by Medicare)**: ______________________

Payor: ☐ Insurance cards attached ☐ If insurance cards not available, then please fill in info below:
Medicare? Card/ID#: ______________________ Patient currently: Part A: __________ Part B: ____________
Insurance? Carrier: ______________________ Auth#: ______________________________
Insured's name: ______________________ Relationship to patient: ______________________
Co-Insurance? Medicaid#: ______________________ Other: ______________________________

Reason for referral: ☐ **increased difficulty with swallowing** ☐ **progress in therapy** ☐ **other:** ________________

Has the patient had a prior instrumental swallowing eval? NO YES when? ______________________

If yes, was the prior study with our company? NO YES when? ______________________

Is this patient currently on a PO diet? NO YES specify ______________________

Is this patient in isolation? NO YES specify ______________________

Does the patient have: trach/vent*/speaking valve? NO YES specify ______________________

Are there any days/times that will NOT work for this patient? NO YES specify ______________________

(*Please note vent dependent patients must have a respiratory therapist present/immediately available for study)

Please email or fax the following with this form, then call the appropriate scheduling office to confirm receipt:

1) PHYSICIAN ORDER

Must state: "Exam and Modified Barium Swallow Study with Patheous Health" and include "Dx Dysphagia" or other relevant medical dx (e.g. Aspiration Pneumonia, CVA, etc..) and include nurse or MD signature as well as the legible printed name (electronic signature notation acceptable)

2) PATHEOUS HEALTH AUTHORIZATION FORM

Can be verbal or signed consent from patient/POA
Facility staff obtaining consent must sign as witness

3) PATIENT'S FACILITY FACESHEET

If facesheet does not include Medicare/insurance info and SS# please send copy of patient insurance cards, SS card or fill in SS# above

4) **COPY OF PATIENT'S BEDSIDE/CLINICAL SWALLOW EVALUATION**

RETAIN THIS PACKET OF INFORMATION AND GIVE TO THE TEAM UPON ARRIVAL IN ADDITION TO THE FOLLOWING:

Copy of patient's current medication list – for physician review on date of study
Patient paper chart (if electronic only, the team will need access OR a copy of at least one of the following: hospital admission H&P, Hospital Discharge Summary, or recent facility H&P)
Set of patient vitals from date of study and patient's last recorded height/weight

CONFIDENTIALITY NOTICE: THE INFORMATION CONTAINED IN THIS MESSAGE MAY BE PRIVILEGED AND CONFIDENTIAL AND IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL(S) OR ENTITIES NAMED ABOVE WHO HAVE BEEN SPECIFICALLY AUTHORIZED TO RECEIVE IT. IF THE READER IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEADIATELY BY TELEPHONE AND RETURN ALL PAGES TO THE ADRESS SHOWN ABOVE. ***(Rev 02-2022)***