MBS Referral Form

To: DFW Scheduling Office
Email: mbs-schedule@patheoushealth.com

Phone: 817-514-6271
Fax: 888-920-1201 or 817-514-6278

Facility Information

Facility Name: City/State: DOB:

Referral Contact Name: Title:

Mobile Phone Number: Email:

Day of Study Contact Name (if different): Title:

Mobile Phone Number: Email:

Patient Details

Patient First Name: Last Name:

Has the patient had a swallow study with us before?	Yes ☐	No ☐
Is the patient on isolation precautions?	Yes ☐	No ☐
Does the patient have a trach/vent*/speaking valve? *Patients that are vent-dependent must have a respiratory therapist immediately available for the study	Yes ☐	No ☐
Was a Bedside/Clinical Swallow Evaluation completed?	Yes ☐	No ☐
Are there any days/time that will NOT work for the patient?	Yes ☐	No ☐

Insurance Information

Attach copy of the patient's Face Sheet (required to schedule a study and validate insurance). Note any changes to the patient's place of service, benefits, or insurance information here:

Clinical Documentation

Please provide the following before your study can be scheduled:

- Signed Physician Order stating "***Physician consult requested for dysphagia consultation to include all medically necessary assessments of swallowing function, including Modified Barium Swallow (MBS) Study for oral and pharyngeal stages, as well as, esophagus and cervical spine assessment.***" and include related diagnosis.
- Patheous Health Authorization Form
    - Verbal or signed consent from patient/POA. Facility staff must sign as witness
- Copy of Bedside/Clinical Swallow Evaluation (if completed)

Please have the following information available when the Patheous Health team arrives on site:

- Access to the patient's chart
- Access to the patient's current medication list
- Set of vitals from the date of study and the patient's last recorded height and weight

Referral made to DiagnosTEX Consultants, PLLC for Dysphagia Consult with MBS

Ordering Provider (full name): _____ Phone: _____ Fax: _____

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

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

Stay: ☐ Skilled ☐ Non-skilled ☐ Assisted Living ☐ Outpatient/Day Rehab ☐ Hospice

Hospice Agency: _____ Hospice Dx(s): _____

Current Diet: Solids_____ Liquids: _____ Trials: _____ Strategies: _____

☐ **Physician consult requested for dysphagia consultation to include all medically necessary assessments of swallowing function, including Modified Barium Swallow (MBS) study for oral and pharyngeal stages, as well as, esophagus and cervical spine assessment.**

ORDERING MD/DO/NP/PA Signature: _____ Date: _____ NPI: _____

Reason for mobile/onsite visit (required)

☐ Physical condition negatively affected by transport ☐ Fatigue level concerns and/or medically unstable

☐ Transportation would negatively affect behavior, cognition, and fall risk ☐ All of the above

Reason(s) for Consult

☐ Coughing ☐ Choking ☐ Globus Sensation ☐ Odynophagia ☐ Recurrent PNA ☐ New onset PNA

☐ Poor PO intake ☐ Weight loss ☐ SOB/Wheezing ☐ Wet phonation ☐ Temperature spikes

☐ Suspect Silent Aspiration ☐ Diet Upgrade ☐ Diet Downgrade ☐ Other: _____

Previous: ☐ Modified Barium Swallow ☐ Fiberoptic Endoscopic Evaluation Swallow Date: _____

Results: _____

Medical Necessity

☐ Dementia ☐ Alzheimers ☐ GERD ☐ PNA ☐ COPD ☐ MR ☐ CP ☐ PD ☐ MS ☐ ALS ☐ HD

☐ MG ☐ Autism ☐ CVA: _____ ☐ Cervical Spine: _____ ☐ Feeding difficulties/dysphagia

☐ TBI/CHI: _____ ☐ Cancer: _____ ☐ Other: _____

Respiratory Status

☐ Room Air ☐ O2: ____L ☐ Trach ☐ PMV ☐ Open Stoma Decannulation Date: _____ ☐ Vent

☐ Hx of intubation ☐ History Smoker/Vape ☐ Current Smoker/Vaper ☐ COVID-19: Date: _____

Dentition (upper and lower)

☐ Natural - U L ☐ Dentures - U L ☐ Partials – U L ☐ Edentulous – U L ☐ Poor dentition – U L

Respiratory Status

☐ Communicates

☐ Follows Commands

☐ Strategy-appropriate

Speech Therapy

☐ New dysphagia eval ☐ Oral/Motor Ex

☐ Hyolaryngeal/Pharyngeal Ex ☐ Vital Stim

☐ Thermal Stim ☐ E-Stim ☐ Cognition/Other

Dysphagia Onset

☐ New ☐ Weeks _____

☐ Months ____ ☐ Years ____