## **MBS Referral Form**

To: Scheduling Office Email: schedule@patheoushealth.com



Phone: 816-866-4643 Fax: 816-817-0922

Facility Information			
Facility Name:	City:		State:
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	ble 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
What is the patient's current diet?			

## **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:

## **<u>Clinical Documentation</u>**

Please provide the following at least one day before the study:

- Signed Physician Order stating "*Exam and Modified Barium Swallow Study*" 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 and current medication list
- Set of vitals from the date of study and the patient's last recorded height and weight

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