Patheous
PEDIATRICS
formerly known as DiagnosTEX

What to Expect for my Child's Swallow Study Appointment

Prior to the appointment: Please fill out the Parent Intake Form, if your child's SLP has not already done so. You may email it to us or bring it on the day of the appointment.

Please bring the following items to your child's appointment:
☐ Preferred cups & pacifiers (straw, sippy, and/or bottle)
☐ Any specialty utensils used for feeding (NUK brushes, adaptive utensils, etc.)
☐ A few of your child's favorite snacks
☐ Any item(s) that could be used as a reward for your child (stickers, favorite toy, snack, etc.)
☐ A bib and a change of clothes in the event your child spits/spills the food/drink
☐ Reports from previous swallow studies, if applicable
☐ Insurance card – must be presented at time of study
☐ Driver's License – must be presented at time of study

Please arrange childcare for siblings - other children are prohibited from entering the Fluoroscopy suite

Day of the appointment

- Please bring items from above that apply to your child.
- The appointment will last approximately 1 hour.
- Your child will be offered a variety of solids and liquids to ensure he/she is consuming a safe diet.
- All recommendations will be reviewed with you following the conclusion of the study.
- You will leave the appointment with written instructions regarding your child's feeding recommendations.
- A written report will be sent to your child's physician and treating SLP.
- No food or formula 1.5 - 2 hours prior to the study. He/she may have water, juice, and milk.

Upon arrival to the clinic

- Please bring your insurance card and driver's license to provide to the front office staff.
- There will be some paperwork to complete upon arrival, as well as the Intake Form if it was not completed prior.
- The Speech-Language Pathologist will escort you & your child to the swallow study room.
- If you are pregnant, please inform the Speech-Language Pathologist prior to the study.

Please call if you have any questions prior to your child's appointment or need to reschedule.

We look forward to meeting you and your child!

Patheous Health
8913 Mid Cities Blvd, Ste 100
North Richland Hills, TX 76182

Phone: 817-514-6271
Fax: 817-514-6278
www.patheoushealth.com

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Pediatric Intake Form

Patient Name: _____ **Date of Birth:** _____

Address: _____ Gender: ☐ M ☐ F

Parent(s)/Legal Guardian(s) Name(s): _____

Phone: _____ Email address: _____

Language(s) Spoke in the Home: _____ Attend daycare/school: ☐ Yes ☐ No

Parents' Main Feeding Concerns: _____

Pediatrician: _____ Name of Office: _____

Birth History

☐ Full-term NICU stay: ☐ No ☐ Yes, Length of stay _____

☐ Pre-term: ____weeks____days Delivery: ☐ Vaginal ☐ C-Section

Complications: ☐ N/A _____

Currently on Reflux Medications: ☐ Yes ☐ No Food Allergies: ☐ N/A _____

Vision Deficits: ☐ Yes ☐ No Hearing Deficits: ☐ Yes ☐ No

Can the child follow simple commands: ☐ Yes ☐ No

Recurrent Respiratory Illnesses: ☐ Yes ☐ No Diagnosis: _____

Previous Swallow Study: ☐ Yes ☐ No If yes, what type of study? ☐ MBSS ☐ FEES

Date: _____ Results: _____

Current Diet and Feeding Strategies: Check all that apply

☐ NPO ☐ GT/NG Dependent ☐ Feeding With Therapy Only
Liquids: ☐ Thin (Regular) ☐ ½ Nectar ☐ Nectar ☐ Honey ☐ N/A
Drinking Mechanism: ☐ Bottle: _____ ☐ Breast ☐ Sippy Cup ☐ Straw cup ☐ Open Cup
Solids: ☐ Age appropriate ☐ Puree ☐ Mashed solids ☐ Soft & bite sized ☐ N/A
Level of assistance during feeding: ☐ Independent ☐ Some assistance ☐ Dependent
Behaviors: ☐ Picky Eating ☐Reflux; Vomiting ☐ Difficulty transitioning to solids ☐ Aversion
Coughing/Choking on: ☐Liquids from a _____ ☐Puree ☐Solids ☐ Secretions

Current Therapy

Speech/Feeding Therapy: ☐ N/A
Therapist's name & contact info: _____
Physical Therapy: ☐ Yes ☐ No Occupational Therapy: ☐ Yes ☐ No

Your child's swallow study can be conducted at your home in our mobile clinic or in our clinic in N. Richland Hills.
Which would you prefer? ☐ mobile clinic ☐ outpatient clinic

Anything you may want us to know prior to the appointment (feeding behaviors, likes/dislikes, etc):

_____

_____

Please call with any questions prior to the appointment – 817.514.6271

Pediatric Physician Referral to DiagnosTEX for Dysphagia Consult with MBS

Please fax this signed order, demographic sheet, and latest clinicals to (888) 920-1201

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

Street Address: _____ City: _____ Zip: _____

Phone Number: _____ Parent Email: _____

Insurance Provider: _____ Subscriber ID: _____

Ordering Provider (Full Name with Credentials): _____
Provider Phone: _____ Provider Fax: _____
Provider Address: _____

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

Reason for Consult:	Medical Necessity:
☐Coughing	☐TBI
☐Choking	☐Feeding Difficulties
☐Respiratory Concerns	☐GERD; Vomiting
☐Vomiting	☐Weight loss or poor weight gain
☐Poor PO Intake; Aversion	☐History of Dysphagia
☐Suspect Silent Aspiration	☐Genetic Anomaly (specify) _____
☐Diet Upgrade	☐Consistent respiratory concerns
☐Other:_____	☐Other _____

Currently receiving Speech/Feeding Therapy: ☐ Yes ☐ No
Treating Speech/Feeding Therapist Name: _____ Phone #:_____
Other specialties involved in patient's care:_____

Other Important Information: _____
_____

ORDERING MD/DO/PA/NP Signature: _____Date:_____NPI:_____
Incomplete referrals will not be processed until all paperwork required is received. Verbal orders can be taken but a written order must be provided for ALL patients. If you have any questions, please call 817-514-6271.

Please remember to include the following:

☐Demographic sheet
☐Most recent medical history & clinical notes

FAX NUMBER: 888-920-1201

If we are unable to reach the family, we will let you know. *A copy of the completed report will be faxed to your office upon completion of the study*. Thank you for coordinating care of your patient with us!

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Cancellation/Late/No-Show Policy

If you need to cancel or reschedule your appointment, you must contact DiagnosTEX ***24 hours prior*** to your scheduled appointment. The phone number is listed above & you may leave a message if it is outside of our office hours. If you prefer to email, please send the email to info@diagnostex.us.

A flat fee of **$100.00** will be billed to you if you are more than 15 minutes late, cancel within less than 24-hours, or do not show up for your child's scheduled appointment. Additionally, if you cancel more than 3 times we will not reschedule at our location.

Consent to use MBS Video for Educational Purposes

I, _____(parent/guardian) hereby give consent for DiagnosTEX, LLC (A Patheous Health Company) to utilize _____ (patient's name) recorded Modified Barium Swallow Study (MBS) for educational purposes, such as conferences, professional training, marketing, and educational courses. By signing this consent, I understand that:

- All audio recording will be removed.
- There will be no identifiable information (i.e.) shared with those viewing the video recording. Information, such as age and diagnosis, may be discussed for the educational purpose of the images/video.
- The video recording will be utilized in conjunction for dysphagia educational purposes only provided by a DiagnosTEX/Patheous employee. However, in the event of a digitally recorded course/copy may be utilized on platforms outside of the control of the DiagnosTEX/Patheous platform. This may or may not be limited to social media sites, continuing education courses, conferences, professional training courses, and/or other digital platforms outside the control of DiagnosTEX/Patheous.

☐ I consent ☐ I do not consent

_____ _____
Parent/Guardian Signature Date

Office use only:
Verbal consent received on _____at _____am/pm.
Date Time

Verbal consent received by: _____ _____
Employee Printed Name Employee Signature