MBS Referral Form

To: Scheduling Office
Email: ohiosched@patheoushealth.com

Phone: 888-225-9227
or 330-923-3502
Fax: 330-923-3507

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? No

Is the patient on isolation precautions? No

Does the patient have a trach/vent*/speaking valve? No
*Patients that are vent-dependent must have a respiratory therapist immediately available for the study

Are there any days/time that will NOT work for the patient? 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 for Exam and Modified Barium Swallow Study
- 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