HH/IL/AL RECENT CLINICALS/PROGRESS NOTES/ORDER BELOW:

Midwest Dysphagia Consultation Scheduling Form
FAX to: 855-208-1848 or 877-200-1382

Required documents to schedule: clinical filled out completely, **face sheet** with insurance information
****Scheduling may be delayed if 1-8 are not completed.** Pts MUST be able to come outside to the for the study by walker or wheelchair. We do have a lift. We do not perform studies at the bedside.**

Email: mdcoffice@proimagetx.com Office Phone: 513-713-0069/855-209-1979

1. Address of where pt to be seen: ______________________________
City:______________ **9-digit Zip Code:**__________ **Special Instructions:**______________
Person completing form : ______________ **Contact # of person completing form:**______________
Patient home/cell phone #: ______________ **Date:** ________ **Fax/email report to:** ________
Check: ☐**Medicare** ☐**Medicaid** ☐**Hospice** ☐**Primary Insurance Name:**__________ #__________
Patient Name:______________ **DOB:** ________ **Sex: M or F Height:**_____ **Weight:**____
2. Ordering Physician (first/last name required):______________________________

3. SYMPTOMS, primary medical reasons for consult (required): coughing coughing with po choking difficulty swallowing feeding difficulty risk of aspiration risk of silent aspiration breathing difficulty with po breathy vocal sounds food/pills getting stuck GERD/Esophageal reflux hoarse vocal quality malnutrition/ dehydration moist cough nausea pneumonia pocketing poor po intake recurrent pneumonia reflux respiratory distress runny nose shortness of breath spitting food/saliva tearing with oral intake vomiting weightloss wet vocal quality wheezing with po

4. Status Change due to : improvement decline weight loss malnutrition pneumonia reduced po
New onset of: increased awareness decreased awareness choking coughing pocketing poor po
Patient swallowing status: BETTER (risk for silent aspiration and/or symptoms above) or **WORSE (see symptoms above)**
Other goals: find safest/least restrictive diet diet upgrade pre-TX feeding eval **Dentition:** natural poor dentures edentulous
Current diet: Regular Mech Soft Puree NPO **Current Liquids:** Regular Nectar Honey Pudding NPO
Duration of symptoms: days weeks months years **Frequency of symptoms**: all po liquids solids pills saliva
Does patient currently have PEG? Yes or No **Communicates**: Y or N **Follows commands:** Y or N
Pertinent Medical History/Diagnosis (Required): Alzheimer's CVA CHF HTN CAD Dementia DM Dysphagia Parkinson's GERD COPD Hip Fx Pneumonia PEG CA other:______________
Current Treatment? Oral/pharyngeal exercises e-stim thermal stim none at this time unknown
Recent Bedside? Y or N **Pt in favor of PEG if suggested**: Yes No Unknown

5. MBSS CONSULTATION ORDER (*Sign Below)

Include all of the below conditional assessments, if medically indicated, as part of a dysphagia consultation including the MBSS-*comprehensive consult for medically complex patients*

- -Esophageal scan-approx. 30% of pts have asymptomatic esophageal dysphagia, view esophageal emptying into stomach
- -Vocal cord assessment-for closure to protect against aspiration
- -Mandibular/dental assessment-for structural integrity/abnormalities and function for chewing/muscular support to evaluate risk for choking with solids to determine appropriate diet level
- -Cervical spine/soft tissue assessment-for structural integrity/abnormalities and function, changes can lead to redirection of bolus increasing risk of aspiration and requiring a different level of strategy use
- -Frontal chest view-for aspiration when aspiration occurs, allows for a risk stratification for aspiration pneumonia
- -Physician consult requested for dysphagia-impact of po intake on prognosis, impact of medication and anatomy, quality of life and rehab candidacy discussion, recommendations for further consult

OR-Write individual component(s) here: *see guidelines at proimagetx.com for further explanation: ______________

6. Check Reason(s) Onsite Visit is Required: ☐ requires supervision and special transport
☐ request due to elevated aspiration risk ☐ transport negatively impacts underlying physical condition
☐ fatigues easily, compromising test participation ☐ transport exacerbates behavioral problems and compromises test participation

7. Signature REQUIRED:X______________ **RN LVN SLP** Physician Signature: ______________
NURSE OR SLP TO SIGN AND CIRCLE CREDENTIALS TO VERIFY VERBAL ORDER (file in chart for physician to sign)

8. Consent (circle) Verbal consent received from patient/legal guardian? ***Yes*** or ***No***

*May require advance beneficiary notice due to lack of Medicare coverage. You will be notified prior to study.