Referral made to Mobile Swallowing Diganostics for Dysphagia Consult with MBSS

Fax completed form to +1 229 537 3814 or email to info@mobileswallowingdx.com

Facility Name: _____ City:_____ Phone:_____
Ordering Provider (Full Name): _____ Phone:_____ Fax:_____
SLP (Full Name): _____ Phone:_____ Fax:_____
Scheduling Contact (Full Name): _____ Phone:_____ Fax:_____
Email Reports: _____
Expected Discharge Date: _____

Patient Name: _____ DOB:_____ Sex: ☐M ☐F
Height:_____ Weight:_____ Room#:_____ Special Precautions:_____
Ambulatory ☐ Walker ☐ Wheelchair ☐ XL Wheelchair ☐ Motorized Chair ☐ Geri Chair ☐

Exam Type: Need CPT codes
Facility ☐ Facility Agency:_____ Facility DX(s):_____
Current Diet: Solids:_____ Liquids:_____ NPO:_____ PEG/NG:_____
Current NOMS:_____ NPO PEG/NG/J-Tube AMA Diet:_____ *Allergies_____
*Barium contains natural strawberry and citrus flavor

☐ Physician consult requested for dysphagia evaluation to include all medically necessary assessments of swallowing function. This may include Modified Barium Swallow Study (MBSS), oral and pharyngeal stage evaluation, esophageal assessment, and cervical spine screening as indicated. Exam type must be selected by CPT code.

Reason(s) for Consult
- ☐ Globus sensation
- ☐ Odynophagia
- ☐ Recurrent pneumonia
- ☐ Aspiration risk or silent aspiration
- ☐ Poor oral intake
- ☐ Weight loss
- ☐ Shortness of breath or wheezing
- ☐ Wet vocal quality or voice changes
- ☐ Persistent upper abdominal pain
- ☐ Suspected peptic ulcer disease
- ☐ Suspected esophageal reflux or GERD complications
- ☐ Hiatal hernia
- ☐ Esophageal diverticula
- ☐ Esophageal cancer or masses
- ☐ Possible obstruction/fistula

Other: _____
Previous: MBSS ☐ FEES ☐
Results: _____
Date: _____

Requested Exams
- ☐ 74220 - Esophagus, single contrast
- ☐ 74221 - Esophagus, double contrast
- ☐ 74240 - Upper GI, single contrast
- ☐ 74246 - Upper GI, double contrast
- ☐ 92611 - Video/Fluro swallow study

Respiratory Status
Room Air ☐ O2 ☐ ____L
Trach ☐ PMV ☐ Open Stoma ☐
Decannulation Date: _____
Vent ☐ HX of intubation ☐
History Smoker/Vape ☐
Current Smoker/Vape ☐
COVID-19 Date: _____

Relevant Medical History:
Dementia ☐ Alzheimer's ☐
CVA: _____
Cervical Spine: _____
Feeding Difficulties/Dysphagia ☐
GERD ☐ PNA ☐ COPD ☐
MR ☐ CP ☐ PD ☐ MS ☐
ALS ☐ HD ☐ MG ☐ Autism ☐
TBI/CHI: _____
Cancer: _____
Other: _____

Dysphagia Onset: ☐New ☐Weeks ☐Months ☐Years

Other Important Info: (please write legibly and provide any scheduling conflicts)

ORDERING MD/DO/NP/PA 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 contact us.