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Corporate Office: 7736 Central Park Drive • Waco, TX 76712

MBSS / DYSPHAGIA CONSULT REQUEST FORM

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Age: _____

Facility: _____ Ordering Physician: _____

Facility/Rehab Phone: _____ Facility/Rehab Fax: _____

SLP/Nursing Contact: _____ Cell/Alternate Number: _____

REASON FOR MBSS/ DYSPHAGIA CONSULT: *(Check all that apply)*

- | | | | |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> s/s Aspiration | <input type="checkbox"/> change in P/O function | <input type="checkbox"/> diet upgrade | <input type="checkbox"/> least restrictive diet |
| <input type="checkbox"/> pleasure feed | <input type="checkbox"/> choking | <input type="checkbox"/> cough | <input type="checkbox"/> distress |
| <input type="checkbox"/> runny nose | <input type="checkbox"/> wet voice | <input type="checkbox"/> low weight | <input type="checkbox"/> Other _____ |

PATIENT CONDITION & DIET

Check all that apply:

COGNITION: Good Fair Poor Vent Trach **ALLERGIES:** _____

DIET STATUS: Peg NPO Regular Mech Soft Puree Pudding Honey
 Nectar Thin Teeth Dentures

AMBULATORY STATUS: Walks without assistance Walker Wheelchair

Geri-Char *** *Please call office for special instructions. MBSS study will be limited due to chair positioning.*

Other Pertinent information: _____

MBSS DIAGNOSIS CODES

PRIMARY DIAGNOSES:

- Pneumonitis 507.0
- Dysphagia Cerebrovascular disease 438.82 (CVA)
- Dysphagia, unspecified 787.20 ** *Secondary Diagnosis Required. Check all that apply.*

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Diffuse Diseases of the Connective Tissue <input type="checkbox"/> Diverticulum of Esophagus, acquired <input type="checkbox"/> Esophageal Reflux <input type="checkbox"/> Feeding Difficulties/Mismanagement <input type="checkbox"/> Hereditary Progressive Muscular Dystrophy <input type="checkbox"/> Malignancies of Head & Neck <input type="checkbox"/> Malignancies of Esophagus | <ul style="list-style-type: none"> <input type="checkbox"/> Motor Neuron Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Quadriplegia/Quadriparesis <input type="checkbox"/> Stricture & Stenosis of Esophagus <input type="checkbox"/> Systemic Sclerosis <input type="checkbox"/> Other _____ |
|---|--|

BILLING TYPE

Is patient in Medicare Part A Covered Stay?

- Yes No

Does patient have Medicare Part B Coverage?

- Yes No

- Medicaid Coverage Only
- HMO/Medicare Managed Care Plan
- Private Insurance Only