Office Use Only

N □ E □ Referral made **29th Street Therapy Center** for **Dysphagia** Consult (including FEES)

INPATIENT HOSPITAL OR OUTPATIENT CLINIC

Once completed, fax to 29th Street Therapy Center at 405-224-0133.

Scheduling Contact Information: Name _____ Relation to Patient_____

Ordering MD: _____ Phone _____Referring SLP _____Phone _____

Agency/Clinic _____ Fax _____Text? Yes □ No □ Signed order on file: Yes □ No □

Order must read "FEES" in order to address dysphagia

Patient Name _____ M F Age____ DOB_____Room#_____Ht_____Wt.____

Patient can consent to consultation for themselves □ OR healthcare proxy has been invoked □ **Contact Precautions? Y□ N□**

Exam to be scheduled at: outpatient clinic □ private residence □ assisted living □ dayhab □ grp home □ other □_____

Street Address_____ Apt/Bldg/Unit _____ Gate Code_____ City _____

Payer Source_____ Policy#_____ (call us at 405-224-0002 for question/assistance)

Reason Mobile/Onsite Visit is Required: Outpatient Clinic □

Physical condition negatively affected by transportation □ Fatigue level concerns and/or medically unstable □

Transportation would negatively affect behavior, cognition and fall risk □ All of the above □

Current Diet: Food Consistency _____ Liquid Consistency _____ Trials _____ Strategies _____

NOMS _____ NPO-PEG/NG/Jtube AMA diet: _____(requires signed ABN) Food Allergies _____

Current Dentition: _____ Self Feeding Status: Total assist □ Supervision □ Independent □

Reason(s) for Consult

Coughing □
Choking □
Dehydration □
Globus Sensation □
Odynophagia □
Recurrent Pneumonia □
New Onset of Pneumonia □
Poor PO Intake □
SOB/Wheezing □
Suspects Silent Aspiration □
Temp Spikes □
Wet Phonation □
Weight Loss □
Wish to Upgrade Diet: _____
Recent BSE DATE_____
Results _____
Recent MBSS DATE _____
Results _____
Recent FEES DATE_____
Results _____

Medical Necessity (describe)

Improvement _____
Decline _____
Current Status _____

Medical History (check all that Apply)

Alzheimer's □
Cancer □ _____
Cervical Spine Surgery □
CVA □
CHF □
COPD □
Dementia □
Feeding Difficulties □
GERD □
MR □
MS □
Parkinson's □
Pneumonia □
TBI/CHI □
Other:_____
Flu Vaccine □ Date: _____
Recent Pneumonia Vaccine □

Respiratory Status

WLF □
O2 □
Trach □
Speaking Valve □
Vent □
Open Stoma □
Hx of Intubation □

Diagnosis

1. _____ICD10: _____
2. _____ICD10: _____
3. _____ICD10: _____
4. _____ICD 10: _____

Dysphagia Onset: New? Yes□ No□

wks _____mos_____yrs_____

Cognition (indicated each item)

Communicates Y N
Follows Commands Y N
Strategy-appropriate Y N

Speech Therapy

None □
Cognition Only □
New Dysphagia Eval □
O – M Ex □
Hyolaryngeal/Pharyngeal EX
Thermal Stim □
ESP □
Vital Stim □ Placement: ____

Other Important Information:

_____
_____
_____

This order is REQUIRED TO SCHEDULE. Please sign:

□ **Physician consult requests for dysphagia consultation to include all medically necessary assessment of swallowing, Including Fiberoptic Endoscopic Evaluation of Swallow (FEES)**

Order MD/NP/ PA Signature _____ Date _____ NPI _____

Telephone or verbal order signed by DON or RN ONLY

Office Use Only

N □ E□ Referral made to **29th Street Therapy Center for Voice** Consult (including FEES)

INPATIENT HOSPITAL OR OUTPATIENT CLINIC

Once completed, fax to 29th Street Therapy Center at 405-224-0133.

Scheduling Contact Information: Name _____Relation to Patient_____

Ordering MD: _____ Phone _____Referring SLP _____Phone _____

Agency/Clinic _____ Fax _____Text? Yes □ No □ Signed order on file: Yes □ No □

Order must read "Videostroboscopy for laryngeal function"

Patient Name _____ M F Age____ DOB_____Room#_____Ht_____Wt.____

Patient can consent to consultation for themselves □ OR healthcare proxy has been invoked □ **Contact Precautions? Y□ N□**

Exam to be scheduled at: outpatient clinic □ private residence □ assisted living □ dayhab □ grp home □ other □_____

Street Address_____ Apt/Bldg/Unit _____ Gate Code_____ City _____

Payer Source_____ Policy#_____ (call us at 405-224-0002 for question/assistance)

Reason Mobile/Onsite Visit is Required: Outpatient Clinic □

Physical condition negatively affected by transportation □ Fatigue level concerns and/or medically unstable □

Transportation would negatively affect behavior, cognition and fall risk □ All of the above □

Allergies to Topical Anesthetic? Yes □ No □

Reason(s) for Consult

Hoarseness □
Breathy voice □
Unsteady voice □
Straining to Speak □
Vocal Fatigue □
Throat Pain □
Heartburn □
Indigestion □
Chronic throat clear □
Allergies □
Chronic Cough □
Wet phonation □
Laryngitis □
Suspect Silent Aspiration □
Upgrade Diet:_____
Recent ENT Exam: _____
Recent MBSS/FEES _____
Results_____

Medical Necessity (describe)

Improvement _____
Decline _____
Current Status _____

Voice Problem Onset: New ___
wks _____mos_____yrs_____

Medical History (check all that Apply)

Alzheimer's □
Cancer □ _____
Cervical Spine Surgery □
CVA □
CHF □
COPD □
Dementia □
Feeding Difficulties □
GERD □
MR □
MS □
Parkinson's □
Pneumonia □
TBI/CHI □
Thyroidectomy □
Intubation □ Date: _____
Laryngeal Surgery: _____
Other: _____

Respiratory Status

WFL □
O2 □
Trach □
Speaking Valve (PMV) □
Vent □
Open Stoma □
Hx of Intubation □

Vocal Hygiene/ Health

Water intake in oz/day _____
Alcohol intake oz/day _____
Tobacco use: _____
Quit using Tobacco: _____
Secondhand smoke exposure: Yes □ No □
Other: _____

Cognition (indicate each item)

Communicates Y N
Follows Commands Y N
Strategy-appropriate Y N

Current Speech Therapy Y N

Diagnoses

1. _____ICD10: _____
2. _____ICD10: _____
3. _____ICD10: _____
4. _____ICD10: _____

Voice Problem Onset: New? Yes □ No □

wks _____mos_____yrs_____

Other Important Information:

_____
_____
_____

This order is REQUIRED TO SCHEDULE. Please sign:

□ **Physician consult requests for voice consultation to include all medically necessary assessment of voice and laryngeal mechanism, including Laryngeal Videostroboscopy.**

Ordering MD/NP/PA Signature Date NPI

Telephone or verbal order signed by DON or RN ONLY