

Office Use Only

N E Referral made **ADVANCED DYSPHAGIA DIAGNOSTIC** 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 **ADVANCED DYSPHAGIA DIAGNOSTIC 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