



FEESABLE SWALLOW SOLUTIONS & REHABILITATION, INC

Referral and Authorization Form

Facility Contact Information

Facility Name: _____ Treating SLP: _____
Contact Phone # _____
Contact Email: _____
Ordering Physician: _____

Signed order on file: Yes No

Patient Information

Patient Name: _____ DOB: _____ Age: _____ Sex: M/F
New Evaluation: On caseload: Payer Source: _____

Diagnoses: 1. _____ ICD10: _____ 2. _____ ICD10: _____
3. _____ ICD10: _____ 4. _____ ICD10: _____

History of Present Illness/PLOF: _____

Previous CSE: Yes No Date: _____ Findings: _____

Previous MBSS: Yes No Date: _____ Findings: _____
Previous FEES: Yes No Date: _____

Findings: _____

Tube feeding: Yes No Type: _____ Current Diet: Solids: _____ Liquids: _____

Comments: _____

Self-feeding status: Total Assist Supervision Independent

Current Compensatory Strategies: (circle)

Small bites/sips	Effortful swallow
Chin tuck	Meal prep
Head turn R L	Double swallow
Sweep: Finger Lingual	Slow rate of PO intake



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Food allergies: Yes No List:
Pulmonary status: WFL O2 nasal cannula Trach Vent Speaking valve
Isolation: Yes No Status:
Cognition: WNL Impaired Follows Directions: Yes No Strategies functional: Yes No

Reason for referral:

- Coughing/choking
- Reduced PO intake
- Recurrent pneumonia
- Suspect silent aspiration
- Wet/"gurgly" vocal quality
- Diet upgrade
- Weight loss
- Globus sensation Other:

Suggested time for visit: M T W Th F Morning Afternoon

Specific time: _____

Additional information (i.e., prefers soda, family brings in snacks, posture issues, dialysis schedule, etc.):

I have discussed the FEES procedure with the patient and/or their POA, explaining the risks and benefits of the examination. By signing below, I also confirm that the Administrator or their designated representative has agreed to authorize Feesable Swallow Solutions, INC to provide this service.

SLP Signature: _____

Date: _____

Please submit all of the following required paperwork Feesable Swallow Solutions, Inc.

- Patient face sheet
- This completed Referral and Authorization Form
- Physician Order that must read, "FEES in order to address dysphagia."

PHONE: (337) 247-7101 FAX: (337) 901-5037 WEBSITE: www.swallowsolutionsllc.com EMAIL: info@swallowsolutionsllc.com



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