MBS MOBILE IMAGING

Referral made to MBS-Mobile Imaging for Dysphagia Consult with MBSS

Facility Name: _____ City:_____ Phone:_____

Ordering Provider (Full Name):_____ Phone:_____ Fax:_____
SLP Full Name:_____ Phone:_____ Fax:_____
Scheduling Contact Name:_____ Phone:_____
E-mail Reports:_____
Expected Discharge Date:_____

Patient Name: _____ DOB:_____ Sex: M or F

Height:_____ Weight:_____ Room#:_____ Special Precautions:_____
Ambulatory ☐ Walker ☐ Wheelchair ☐ XL Wheelchair ☐ Motorized Chair ☐ Geri Chair ☐

Stay: Skilled ☐ Non-Skilled ☐ Assisted Living ☐ Outpatient/Day Rehab ☐
Hospice ☐ **Hospice Agency:** _____ **Hospice DX(s):**_____
Current Diet: Solids_____ Liquids_____ Trials_____ Strategies_____
Current NOMS:_____ **NPO** ☐ **PEG/NG/J-Tube** AMA diet:_____ ****Allergies**_____
****barium contains natural strawberry and citrus flavor

☐ **Physician consult requested for dysphagia consultation to include all medically necessary assessments of swallowing function, including Modified Barium Swallow Study (MBSS) for oral and pharyngeal stages, as well as, esophagus and cervical spine assessment.**

Reason for Mobile/Onsite visit is required: (check all that apply) Physical condition negatively affected by transport: ☐ Fatigue level concerns and/or medically unstable: ☐ Transportation would negatively affect behavior, cognition and fall risk: ☐ **All reasons** ☐

Reason(s) for Consult:
Coughing ☐ Choking ☐
Globus Sensation ☐
Odynophagia ☐ Recurrent PNA ☐
New onset PNA ☐ Poor PO intake ☐
Wt Loss ☐ SOB/Wheezing ☐
Wet Phonation ☐ Temp Spikes ☐
Suspect Silent Aspiration ☐
Diet Upgrade ☐ Diet Downgrade ☐
Other:_____

Previous: BSE ☐ **MBSS** ☐ **FEES** ☐
Results:_____
Date:_____

Dysphagia Onset: New ☐
Weeks ☐ Months ☐ Year(s) ☐

Vaccines: Flu ☐ PNA ☐ COVID ☐

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

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:_____

Dentition (upper and lower)
Natural U L Poor Dentition U L
Dentures U L Partials U L
Edentulous U L
Other:_____

Cognition (indicate EACH item)
Communicates Y N
Follows Commands Y N
Strategy-appropriate Y N

Speech Therapy None ☐
New Dysphagia Eval ☐
Oral/Motor Ex ☐
Hyolaryngeal/Pharyngeal Ex ☐
Cognition/Other ☐
Thermal Stim ☐
E-Stim – Ampcare ESP ☐
Vital Stim ☐

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

ORDERING MD/DO/NP/PA Signature:_____

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 call 725-250-5885.