



# Referral made to Mobile Swallowing Diagnostics

Fax completed form to +1 229 537 3814 or email to [info@mobileswallowingdx.com](mailto:info@mobileswallowingdx.com)

**Facility Name:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Ordering Provider (Full Name):** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**SLP (Full Name):** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Scheduling Contact (Full Name):** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
**Email Reports:** \_\_\_\_\_  
**Expected Discharge Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Sex:**  M  F  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Room#:** \_\_\_\_\_ **Special Precautions:** \_\_\_\_\_  
 Ambulatory  Walker  Wheelchair  XL Wheelchair  Motorized Chair  Geri Chair

**Exam Type: Need CPT codes**

Facility **Facility Agency:** \_\_\_\_\_ **Facility DX(s):** \_\_\_\_\_  
**Current Diet: Solids:** \_\_\_\_\_ **Liquids:** \_\_\_\_\_ **NPO:** \_\_\_\_\_ **PEG/NG/J-Tube:** \_\_\_\_\_  
**Current NOMS:** \_\_\_\_\_ **NPO** **AMA Diet:** \_\_\_\_\_ **\*Allergies** \_\_\_\_\_  
\*Barium contains natural strawberry and citrus flavor

Physician consult requested for dysphagia evaluation to include all medically necessary assessments of swallowing function. This may include Modified Barium Swallow Study (MBSS), oral and pharyngeal stage evaluation, esophageal assessment, and cervical spine screening as indicated. Exam type must be selected by CPT code.

**Reason(s) for Consult**

- Globus sensation
- Odynophagia
- Recurrent pneumonia
- Aspiration risk or silent aspiration
- Poor oral intake
- Weight loss
- Shortness of breath or wheezing
- Wet vocal quality or voice changes
- Persistent upper abdominal pain
- Suspected peptic ulcer disease
- Suspected esophageal reflux or GERD complications
- Hiatal hernia
- Esophageal diverticula
- Esophageal cancer or masses
- Possible obstruction/fistula

Other: \_\_\_\_\_

Previous:  MBSS  FEES

Results: \_\_\_\_\_

Date: \_\_\_\_\_

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

ORDERING MD/DO/NP/PA Signature: \_\_\_\_\_ Date: \_\_\_\_\_ NPI: \_\_\_\_\_

**Requested Exams**

- 74220 - Esophagus, single contrast
- 74221 - Esophagus, double contrast
- 74240 - Upper GI, single contrast
- 74246 - Upper GI, double contrast
- 92611 - Video/Fluoro swallow study

**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: \_\_\_\_\_

**Relevant Medical History:**

- Dementia  Alzheimer's
- CVA:** \_\_\_\_\_
- Cervical Spine:** \_\_\_\_\_
- Feeding Difficulties/Dysphagia
- GERD  PNA  COPD
- MR  CP  PD  MS
- ALS  HD  MG  Autism
- TBI/CHI:** \_\_\_\_\_
- Cancer:** \_\_\_\_\_
- Other:** \_\_\_\_\_

**Dysphagia Onset:**  New  Weeks  
 Months  Years

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 contact us.