MBS ADVANTAGE INC

PATIENT REFERRAL FORM

** PLEASE FILL IN **ALL** INFORMATION!! **

FAX TO 314-842-9185

Facility _____

Address _____

Ph # _____ Fax # _____

Contact Name _____ Title _____

Ordering Physician _____

Ph # _____

Patient _____

SS# _____

DOB_____ Age____ M / F Civil Status: M/ W/ D/ S

Financial Responsible Party _____

Circle one:

Medicare A Medicare B Insurance Other _____

Medical Information

Diagnoses:

- ☐ CVA ☐ Multiple CVAs date(s) _____
- ☐ Hemiparesis: L / R
- ☐ CHF
- ☐ COPD
- ☐ Pneumonia: aspiration / other date:_____
- ☐ Acute Respiratory Failure
- ☐ Parkinson's disease
- ☐ Dementia
- ☐ Alzheimer's disease
- ☐ Trach in place ☐ Capped
- ☐ Oxygen in use
- ☐ Dysphagia
- ☐ Aphasia
- ☐ GERD
- ☐ Diabetes
- ☐ Traumatic Brain Injury
- ☐ Other_____

_____

_____

_____

Symptoms ☐Acute ☐Chronic date of onset: _____

- ☐ Weight loss ___lbs/___months
- ☐ Coughing
- ☐ Choking
- ☐ Throat-clearing
- ☐ Wet vocal quality
- ☐ Globus Sensation
- ☐ Vomiting / Regurgitation
- ☐ Recurrent URI/Pneumonia
- ☐ Increased cognition
- ☐ Decreased cognition

Current Diet / Date Started: _____

☐ **NPO:** * feeding tube must be turned off one hour prior to MBS.

☐ G-tube ☐ J-tube ☐ NG-tube ☐ Dobhoff

☐ **PO feedings:**

☐ Regular diet ☐ Mechanical soft ☐ Pureed

☐ Thin liquids ☐ Nectar ☐ Honey ☐ Pudding

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Diagnosis of SLP's bedside evaluation: ☐ Mild ☐ Moderate ☐ Severe ☐ Not completed

Presently in dysphagia therapy or speech therapy? ☐ Yes ☐ No

Previous MBS/FEES results: _____ Date of testing: _____

Reason for this MBS:

☐ To document a dysphagia problem and treatment strategies

☐ To confirm patient improvement and upgrade diet

☐ Other: _____

Thank you for your business

STUDY SCHEDULED FOR _____ (time to be determined) CONFIRMED WITH _____