Referral and Authorization Form

Mobile Endoscopix

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 BSSE: 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:

☐ Small bites/sips ☐ Cough/throat clear & re-swallow ☐ Effortful Swallow
☐ Chin tuck ☐ Meal prep ☐ Slow Rate of PO intake
☐ Head turn: R ☐ L ☐ ☐ Double swallow ☐ Other: _____
☐ Sweep: ☐ Finger ☐ Lingual ☐ Slow Rate of PO intake

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 Mobile Endoscopix to provide this service.

SLP Signature: _____ Date: _____

Please submit all of the following required paperwork to Mobile Endoscopix prior to scheduling:

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

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