Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: ❑ M ❑ F SS#: _____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone#: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Order Information - Dysphagia

Evaluate and treat as indicated:

❑ **Clinical Swallow Evaluation** ❑ **Modified Barium Swallow Study (MBSS)**

❑ **Fiberoptic Endoscopic Evaluation of Swallowing (FEES) @ North Decatur Only**

**If only ordering a MBSS or FEES, please send most recent clinical note(s) documenting medical necessity for procedure.*

Patient History & Diagnosis Information

In order for the Swallowing Team to provide the best service for your patient, the following information must be completed and returned to us by **FAX** and your office will be promptly notified of the appointment date/time.

Note: Patients should register @ Central Patient Registration before proceeding to Radiology, except those transported via stretcher must first register through the Emergency Department Registration.

Past Medical History (Especially Cardiac, Respiratory, GI, & Neuro - a copy of H&P and most recent office note is desired):

_____

_____

Diagnosis: _____

ICD-CM Diagnosis Code: _____

Current Diet: _____ Feeding Tube: ❑ Yes ❑ No

Medications: _____

Allergies: _____

Transfer Assist: ❑ None ❑ Min ❑ Mod ❑ Max ❑ Dependent

Able to sit upright: ❑ Yes ❑ No Weighs 300 lbs. or more: ❑ Yes ❑ No

If patient is a NURSING HOME resident, MUST be accompanied by caregiver!

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License#: _____

Physician Address: _____ Phone#: _____ Fax #: _____

I herby certify that the services indicated in the above order form are medically necessary.

Physician Signature: _____ Date: _____ Time: _____

DeKalb Medical

N. Decatur - FAX Orders to: 404.501.7186
Phone: 404.501.5140
Hillandale - FAX order to: 404.501.8387
Phone: 404.501.8140

P S - 1 0 5 6

OUTPATIENT REHABILITATION DYSPHAGIA ORDER FORM

DMC FORM # PS-1056 (02/10/17)