Dynamic Medical Solutions, Inc. (DMS)

3500 S. Boulevard, Suite 18 B

Edmond, OK 73013

Pre-Study Information

Please have these items ready **BEFORE** the patient is to be seen.

1) **Physician's Order.** The physician's order must read: "**RADIOLOGIC DYSPHAGIA EVALUATION"**.
2) **DMS Patient Authorization** form.
3) **Admit/Face Sheet** (patient's Facility/Home)**.**
4) **DMS Patient Referral Form** (COMPLETED).
5) **Supplemental Insurance Information.**
6) **Copy of Medicare Card & Supplemental Card** (if available)**.**

Please have copies of these items ready for our team **when we arrive** at your facility.

Physical Accommodation Notes:

1) No wheelchairs wider than 34 inches. Our mobile unit lift can, currently, ONLY accommodate wheelchairs up to 34 inches.
2) No geri-chairs or electric wheelchairs.

Please ensure that your patient or resident is awake and ready, and in an appropriate wheelchair. Also, please ensure your patient or resident is dressed in appropriate attire for the schedule day weather.

Proper planning and preparedness will ensure an efficient and effective study for your patient or resident, and your staff.

Your cooperation is sincerely appreciated.

Physician's Order

Date: _____ / _____ / _____

Attention Dr. _____

Your patient, _____, is exhibiting the following:

Coughing/Choking _____

Weight loss _____

Feeling food/pills getting stuck in throat _____

Change in p.o. function _____

Signs/Symptoms of silent aspiration _____

Other (description): _____

_____

_____

May we order a Radiologic Dysphagia Evaluation (videoflouroscopy of all stages of swallow function) for further assessment?

Proceed with order (acceptance) _____

Do not proceed with order (denial) _____

Physician Signature: _____

Date: _____ / _____ / _____

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PATIENT AUTHORIZATION

I hereby grant permission for Dynamic Medical Solutions, Inc. to administer barium for the purpose of diagnosing abnormalities of the swallowing function as well as the thoracic esophagus and cervical spine.

I further authorize the release of any and all information required by Dynamic Medical Solutions, Inc., for services furnished me in order to process insurance claims in my behalf.

In consideration of services rendered or to be rendered, I hereby irrecoverably assign and transfer mentioned policies of insurance. I hereby authorize the insurance carrier(s) to pay directly to Dynamic Medical Solutions, Inc., for all charges in excess of the sums actually paid pursuant to said policies.

A photostatic copy of this ***Patient Authorization*** form shall be considered as effective and valid as the original.

I also hereby agree to pay for any and all emergency medical services dispatched by Dynamic Medical Solutions, Inc., on my behalf whether utilized or refused by me.

Resident's Name: _____

Print Name of Signer: _____

Signature of Resident or Responsible Party: _____

Verbal Consent Received From: _____

Date: _____ / _____ / _____

Witness: _____ Date: _____ / _____ / _____

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Patient Referral Form

Patient Information

Patient Name: _____ Date of Birth: _____ Sex: M _____ F _____

Responsible Party Address: _____
Street/PO Box City State Zip

Facility Name: _____ Physician: _____
First Last

Referring Physician's NPI Number: _____ (may be obtained from physician's office)

Facility's Speech Language Pathologist: _____

Patient DX(s): _____

_____

Communication/Cognitive Status: Good: _____ Fair: _____ Poor: _____

Would patient be able to perform compensatory techniques (chin tuck): _____ Yes _____ No

Current Diet Level: _____ with _____ liquids (_____ cup _____straw)

Alternative Feeding (please specify): _____

Would you like to assess for potential upgrade of diet? _____ Yes _____ No

Medications: _____ Whole _____ Crushed _____ PEG

Self-Feeder? _____ Yes _____ No Fed by staff? _____ Yes _____ No

REASON FOR CONSULT (signs and symptoms of dysphagia)

_____ Coughing _____ Choking _____ Difficulty Swallowing _____ Weight Loss _____ History of Pneumonia

_____ Current Pneumonia _____ Respiratory Distress _____ Wet/Gurgly Phonation _____ Pocketing _____ Diet Upgrade

_____ Pre-Treatment Diagnostic Evaluation of Swallow, high risk Diagnosis _____ Other (describe) _____

Vitals: BP _____ Pulse _____ Temp _____ Respiration _____

REMINDERS:
If patient consumes **carbonated liquids** and you would like to assess the safety of the consistency, please provide a can on the tray.
If patient presents with a mod-severely delayed swallow reflex, please provide **Lemon Ice** on the tray.

INSURANCE INFORMATION

Insurance Type (circle one): **Part A** (Skilled) or **Part B** or **Other** (please specify below)

If **Other**, please list insurer: _____ Policy Number: _____

Medicare Number: _____ Medicaid Number: _____

Secondary Insurance: _____ Policy #: _____ Group # _____

Claims Mailing Address: _____
Street/PO Box City State Zip

IMPORTANT! ALL PHYSICIAN'S ORDERS MUST BE SIGNED BY PHYSICIAN BEFORE STUDY IS SCHEDULED.