Patheous HEALTH

PATIENT REFERRAL FORM

NC MBS Referrals
TO: Scheduling Office
EMAIL: ncschedule@patheoushealth.com

PHONE: 984-259-1501
FAX: 984-259-1501
 # PAGES WITH COVER SHEET: ___

FROM: ______________________ **PHONE:** **FAX:**

DON:____________ **ADM:** ____________ **SLP & CELL:** ____________________

Patient Name: ______________________ DOB: ____________ **Code Status**: ________

Ordering Physician: **NPI# (Required by Medicare)**:

Payor: Insurance cards attached? If insurance cards are not available, please fill in the information below:

Medicare? Card/ID#: ____________ Patient is currently: Part A Part B Assisted/Independent Living

Insurance? Carrier: ________________ Auth#: ________________
Insured's name: ________________ Relationship to patient: ________________
Co-Insurance? Medicaid#: ________________ Other:

Reason for referral: **increased difficulty with swallowing** **progress in therapy** **other:**

Has the patient had a prior instrumental swallowing eval?	Yes	No	when? ____________
If yes, was the prior study with our company?			when? ____________
Is this patient currently on a PO diet?	Yes	No	specify ____________
Is this patient in isolation?	Yes	No	specify ____________
Does the patient have a trach/vent*/speaking valve?	Yes	No	specify ____________
Are there any days/times that will NOT work for this patient?	Yes	No	specify ____________

(*Please note patients that are vent-dependent must have a respiratory therapist immediately available for study)

Please email or fax the following with this form:

1) SIGNED PHYSICIAN ORDER

Must state: "Exam and Modified Barium Swallow Study with Patheous Medical" and include "Dx Dysphagia" or other relevant medical dx (e.g., Aspiration Pneumonia, CVA) and include nurse or MD signature as well as the legible printed name (electronic sign/notation acceptable). If a clinical/bedside evaluation was not completed, please add "Negate clinical swallow eval".

2) PATHEOUS HEALTH AUTHORIZATION FORM

Can be verbal or signed consent from the patient/POA
Facility staff obtaining consent must sign as a witness.

3) PATIENT'S FACILITY FACE SHEET

If the face sheet does not include Medicare/insurance info and SS#, please send a copy of the patient's insurance card, SS card or fill in the SS# above.

4**) COPY OF THE PATIENT'S BEDSIDE/CLINICAL SWALLOW EVALUATION** (if none completed, see #1 above).

RETAIN THIS PACKET OF INFORMATION AND GIVE TO THE TEAM UPON ARRIVAL IN ADDITION TO THE FOLLOWING:

- **Copy of patient's current medication list – for physician review on date of the study**
- **Patient paper chart** (if electronic, the team will need access OR a copy of at least one of the following: Hospital Admission H&P, Hospital Discharge Summary, or Recent Facility H&P)
- **Set of patient vitals from the date of study and patient's last recorded height/weight.**

CONFIDENTIALITY NOTICE: THE INFORMATION CONTAINED IN THIS MESSAGE MAY BE PRIVILEGED AND CONFIDENTIAL AND IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL(S) OR ENTITIES NAMED ABOVE WHO HAVE BEEN SPECIFICALLY AUTHORIZED TO RECEIVE IT. IF THE READER IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AND RETURN ALL PAGES TO schedule@patheoushealth.com *(Rev 01-2024))*