

**PATIENT REFERRAL FORM**

MO\_STL Referrals  
TO: Scheduling Office  
EMAIL: [schedule@patheoushealth.com](mailto:schedule@patheoushealth.com)

PHONE: 314-842-1900  
FAX: 314-842-9185  
# 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.**