

# MBS Referral Form

To: Scheduling Office  
Email: [pdavis@patheoushealth.com](mailto:pdavis@patheoushealth.com)

Phone: 800-552-6103  
or 913-359-6001  
Fax: 913-359-5552

## Facility Information

Facility Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Referral Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Mobile Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Day of Study Contact Name (if different): \_\_\_\_\_ Title: \_\_\_\_\_  
Mobile Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

## Patient Details

Patient First Name:	Last Name:		
Has the patient had a swallow study with us before?	Yes	No	
Is the patient on isolation precautions?	Yes	No	
Does the patient have a trach/vent*/speaking valve?	Yes	No	
<small>*Patients that are vent-dependent must have a respiratory therapist immediately available for the study</small>			
Was a Bedside/Clinical Swallow Evaluation completed?	Yes	No	
Are there any days/time that will NOT work for the patient?	Yes	No	

## Insurance Information

Attach copy of the patient's Face Sheet (required to schedule a study and validate insurance). Note any changes to the patient's place of service, benefits, or insurance information here:

## Clinical Documentation

Please provide the following at least one day before the study:

- Signed Physician Order stating "**Exam and Modified Barium Swallow Study**" and include related diagnosis.
- Patheous Health Authorization Form
  - Verbal or signed consent from patient/POA. Facility staff must sign as witness
- Copy of Bedside/Clinical Swallow Evaluation (if completed)

Please have the following information available when the Patheous Health team arrives on site:

- Access to the patient's chart
- Copy of the patient's current medication list
- Set of vitals from the date of study and the patient's last recorded height and weight