MBSS Imaging Masters, LLC
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RX: Modified Barium Swallow Study/VFSS_____
Modified Barium Swallow Study/VFSS and Dysphagia treatment therapy_____

Patient Name:_____ DOB:_____
Patient Phone #_____ Gender: ☐ Male ☐ Female
Patient Address:_____
Ordering Physician Name:_____ Phone Number:_____
Medicare Number:_____
Insurance Name _____ ID Number:_____ Group Number:_____

Reason for MBSS/Dysphagia consultation: (check all that apply)

__Coughing ___Choking ___S/S Aspiration ___Pleasure Feed ___Weight loss ___Pneumonia

___Difficulty Swallowing ___Change in P/O Function ___Pocketing ___Least Restrictive Diet

___Diet Upgrade ___Pre-treatment diagnostic evaluation of swallow, High risk diagnosis

___Wet/Gurgle Phonation ___Respiratory Distress ___GERD

Patient Condition & Diet: (check all that apply)

COGNITION: __Good ___Fair ___Poor **ALLERGIES:**_____
RESPIRATORY: ___Vent ___Trach ___O2 **INFECTIOUS DISEASE:**_____
DIET STATUS: __Peg __NPO __Regular __Soft __Mech soft __Puree __Pudding __Honey __Nectar __Thin
DENTAL STATUS: __Teeth __Dentures
AMBULATORY STATUS: __Walks independently __Wheelchair __Walker/Cane

In making this referral physician certifies the medical necessity of MBSS and/or Treatment.
Physician Name:_____ Date:_____
Physician Signature:_____