Dynamic Medical Solutions, Inc.

3500 S. Boulevard, Suite 18 B
Edmond, OK 73013

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.