# MASSTEX IMAGING, LLC

**100 CUMMINGS CENTER 106B - BEVERLY, MA 01915**
**Phone: 1-800-508-6277/978-232-0300**
**FAX #: 978-232-0330**

# INTAKE

**Date Sent:** __________________ **Form Completed By:** ________________________________________

**Facility Speech Pathologist:** _____________________________ **SLP Cell #:**____________________________

**SLP Email:** _______________________________________________

**Facility Name:** _____________________________________ **Facility Phone #:** ____________________________

**Address:** _____________________________________**City:** _____________________ **State: MA RI CT NH ME**

**Please CIRCLE One:** Medicare A, Medicare B, Medicaid #_______________________________
Other________________________________ Preauthorization (if applicable) #_______________________

**Patient Name:** ______________________________________ **DOB:** ____________ **Age:** ________ **Sex:** _________

**Social Security#**____________________________ **Room #:** _____________

**Referring Physician:** ____________________________________________________ ***(Please print first and last name)***
**MD NPI:** ___________________________

**Reason for Consult:** ____**choking** ____ **coughing** ___**diet upgrade** ____**difficulty swallowing** ___**pneumonia**
___**pre-treatment diagnosis evaluation of swallow, high risk diagnosis** ___**respiratory distress** ____**s/s of aspiration**
___ **s/s of Dysphagia** ___**weight loss** ___**wet/gurgly phonation Other:**________________________________________

**Pertinent Medical History/Primary Diagnosis:** ____ **Alzheimer's** ____**CHF** ___ **COPD** ___**CVA** ___**Dementia**
___**Parkinson's Dz** ___**Pneumonia Other:** ____________________________________________________________

**If Head/Neck Cancer please indicate type, stage and treatment:**_______________________________________________

**Previous MBS (date and results):** ________________________________________________________________

**Is patient on Oxygen:** ___**yes** ____ **no**
**Cognitive Status:** ________**Follows one step commands** __________**Candidate for strategies**
**Does patient have food allergies:** _________________________________________________________________

**Current Diet:**
**Textures:** ___Regular ___Mech Soft ___ Ground ___Pureed ___NPO Other:____________________________________
**Liquids:** ___Thin ___Nectar ___Honey ___Pudding _____NPO **Does patient have:** ___NGT ____G-Tube ___ J-Tube

**Precautions:** ___**no** ___**yes: Type/reason:**__________________________________________________________

**Special Requests:** __________________________________________________________________________

*** NOTE: Maximum wheelchair width = 32 inches***

**PLEASE CHECK ( √) OFF: (Following items required prior to scheduling appointment)**

_____ **Patient/HCP has consented to procedure**
_____ **Signed MD order: MUST READ: "Dysphagia consultation including MBSS due to swallowing difficulty."**
_____ **Faxed to MassTex Imaging- Intake Form, Signed Dr Order, Face Sheet**

MassTex use only:
Date received ___________ Initial phone call to facility___________ Tentative date/day with ________________________
Noted orders received ______Face sheet received ______Insurance info checked _______ Previous MBSS_________________
Confirmed date/time with________________________________________________ Staff initials_________________________