LAMAR UNIVERSITY
SPEECH & HEARING DEPARTMENT

REQUEST FOR MODIFIED BARIUM SWALLOW ORDER

Patient Name: _____ DOB: _____ Age: _____

Patient Address: _____Patient Phone # _____

Patient's physician: _____Physician Phone # _____

Form Completed by: _____

Date: _____ Phone # _____

Reason for Consult: **s/s of dysphagia** (check all that apply)

___coughing **___choking** **___difficulty swallowing**
___weight loss **___pneumonia** **___respiratory distress**
___wet/gurgly phonation **___pocketing** **___diet upgrade**
___pre-treatment diagnostic evaluation of swallow, high risk diagnosis

Current Diet:

___Regular ___Mech Soft ___Pureed ___NPO

Current Liquids:

___Regular ___Nectar ___Honey ___Pudding

ORDER

Dear Physician,

Due to the patient's present signs and symptoms of dysphagia, a Modified Barium Swallow Study is recommended to rule out aspiration/penetration. Please indicate which hospital you prefer the MBS to be completed and sign and date below indicating your approval of the MBS order.

Hospital where MBS is to be completed: _____

Physician's Name Printed: _____

Physician Signature: _____ Date: _____

Please fax back to the SLP requesting the order at (409) 880-2265.