Mississippi Dysphagia Specialists

Referral and Authorization Form

Phone: (601) 906-3443/ Email: mdsfees@gmail.com/ Fax: 769-447-4977

Facility and Contact Information

Facility Name: _____ Treating SLP: _____

Contact Phone:_____ Contact Email: _____

Ordering Physician: _____

Patient Information:

Patient Name: _____ DOB: _____ AGE:_____ Sex: M F

Diagnosis:_____

History of Present Illness: _____

_____

Previous BSSE: Y N Date: _____ Findings:_____

Previous MBSS: Y N Date: _____ Findings:_____

Previous FEES: Y N Date: _____ Findings: _____

Tube Feedings: Y N Type:_____ Current Diet:_____

Pulmonary Status: WFL 02 Nasal Canula Trach Vent Speaking Valve

Cognition: WFLImpaired Follows Directions Other: _____

Reasons for Referral:

Coughing/Choking	Reduced PO Intake	Recurrent Pneumonia
Suspect Silent Aspiration	Wet "Gurgly" voice quality	Slow Rate of PO
Weight Loss	Global Sensation	Other:_____

Suggested Time For Visit:_____ **Additional Information**:_____

I have discussed the FEES procedure with the patient and/or their POA, explaining the risks and benefits of the examination. By signing below, I also confirm that the Administrator of their designated representative has agreed to authorize Mississippi Dysphagia Specialists to provide this service:

SLP Signature:_____ **Date:**_____