MBS Imaging, LLC

COMPLETE CONVENIENT COST-EFFECTIVE

Simply send MBS Imaging a referral:

Sending Referrals

- Simply Fax or Email us a copy of:
  1. **Doctors Order** (from the chart)
  2. **Face sheet** (from the chart)
  3. **Patient Consent Form** (attached)
  4. **Dysphagia Consult Request Form** (attached)
- You will receive a call scheduling the test the day before with a designated 2-hour window.

Day of Evaluation

- The MBS team will call or text the person listed as the **contact** when 20 minutes away.
- Please have the patient ready in the front lobby.
- Therapists, Nursing, and Family are welcome to observe the evaluation.

Receiving Results

- MBS Imaging provides a **DVD copy** of the exam immediately after the evaluation and a written **diet recommendation slip**.
- Our **detailed written report** will be emailed or faxed the same day.

Welcome to **MBS Imaging**

Chicagoland's only **complete** mobile dysphagia diagnostic solution. MBS imaging specializes in the management of patients with **swallowing problems**. MBS serves over 250 SNFs, Assisted Living, CCRCs, and Home Health companies by providing on-site endoscopic and fluoroscopic instrumental swallow evaluations at the fingertips of healthcare providers with an unrivaled timely and cost-effective service.

- Multilingual staff
- Can fit any size wheel chair
- MBSS and FEES
- **Ideal** service for patients who are coughing while eating, developing wet voice, complaining of food sticking, desiring a diet upgrade, choking, or more.

Contact Info

P: 877-495-7152
F: 877-495-7208
fax@mbsimaging.com

MBS IMAGING, LLC

Mobile Dysphagia Diagnostic Solutions

Facility Check List MBSS/VFSS

1. Please submit all required information listed below:

   ☐ MBSS/DYSPHAGIA CONSULT REQUEST FORM

   ☐ AUTHORIZATION FORM SIGNED BY PATIENT/RESPONSIBLE PARTY

   ☐ COPY OF PHYSICIAN'S WRITTEN ORDER

   ☐ COPY OF PATIENT'S FACE SHEET WITH INSURANCE INFORMATION

   ☐ IF POSSIBLE, A COPY OF PATIENT'S MEDICARE, MEDICAID, OR OTHER INSURANCE CARDS

2. Facility staff is responsible for having the patient(s) in a wheelchair with **VITAL SIGNS** ready for the study before the estimated arrival time.

WE APPRECIATE YOUR REFERRAL – THANK YOU!

1919 S. Highland Ave. Building (C) Suite 100 Lombard, IL 60148 *Phone*: (877) 495-7152 • *Fax*: (877) 495-7208

MBS IMAGING, LLC

Mobile Dysphagia Diagnostic Solutions

MBSS/VFSS: DYSPHAGIA CONSULT REQUEST FORM

Patient Name: _____ ☐ M or ☐ F

DOB: _____ AGE: _____ Ordering Physician's Name: _____

Facility: _____ Patient Hall / Room #: _____

Facility or Rehab Phone #: _____

Facility or Rehab Fax #: _____

SLP or Nurse Contact Number or Cell Phone: _____

REASON FOR MBSS/DYSPHAGIA CONSULT: (Check ALL that apply)

☐ s/s Aspiration ☐ determine compensatory strategies needed ☐ diet upgrade ☐ pleasure feed

Description of swallowing problem:_____

Current Therapy progress:_____

□ Request for A/P view

PATIENT CONDITION & DIET: (Circle ALL that apply)

COGNITION: Good Fair Poor ALLERGIES:_____

RESPIRATORY: Vent Trach NC Amount of 02_____ INFECTIOUS DISEASE:_____

DIET STATUS: Peg NPO Regular Soft Mech Soft Puree Pudding Honey Nectar Thin

DENTAL STATUS: Teeth Dentures Edentulus AMBULATORY STATUS: Walks independently Wheelchair Walker Geri-Chair (*Please call office for special instruction)*

****** PLEASE SEND LIST OF DIAGNOSIS FROM YOUR FACILITY OR HOME HEALTH AGENCY. PLEASE LIST BELOW ANY OTHER PERTINANT SPEECH/SWALLOW DX OR INFORMATION REGARDING LAST HOSPITALIZATION.**

_____

_____

_____

_____

_____

_____

Please List Type of Insurance:

- ☐ Part A Covered Stay (SNF)
- ☐ Medicare Part B (speech therapy bill)
- ☐ Medicaid Only
- ☐ HMO/ Managed Care
- ☐ Private Insurance

Cash Pay _____

MBS IMAGING, LLC

Mobile Dysphagia Diagnostic Solutions

AUTHORIZATION FORM FOR MOBILE MODIFIED BARIUM SWALLOW STUDY

SECTION 1	Procedure Authorization

I hereby authorize MBSS Mobile to:

- Perform a Mobile Modified Barium Swallow (MBSS/VFSS) Study, in order to obtain an objective assessment of the swallowing function and to provide evaluation recommendations for diet, nutrition, compensatory strategies and other appropriate referrals.

SECTION 2	Billing Authorization

I hereby authorize:

- The release of any and all information required by MBSS Mobile for services furnished to me in order to process insurance claims on my behalf. In consideration of services rendered. I hereby assign and transfer to MBSS Mobile all rights, titles and interest benefits payable on all of my insurance carriers.
- The insurance carriers (Medicare Part B, Medicaid, or other Private Insurance) listed on the patient face sheet to pay directly to MBSS Mobile all benefits due under said policies by reason of services rendered herein. In the event the insurance carriers reimburse the patient in error, payment will be directly forwarded to MBSS Mobile for payment.

I will pay MBSS Mobile:

- The 20 percent co-pay and/or deductible remaining from Medicare Part B in the event I have no secondary coverage policy.
- The remaining balance if the patient's private insurance policy does not cover the 20 percent co-pay/or deductible, or if the patient's secondary policy does not cover an MBSS study.
- I will pay the account balance in full. (Either the full price of the test or the 20 percent co-pay /deductible) in the event Medicare Part B and/or Medicaid eligibility cannot be determined.

Patient's Printed Name: _____ Date: _____ / _____ / _____

Patient Signature: _____

Responsible Party or Power of Attorney Signature: _____

If received verbal consent only, please document in medical chart and sign here: _____

The facility must provide a copy of this signed Authorization by the patient (if able), the responsible party, or the person who has Power of Attorney prior to the MBSS being performed. The MBSS cannot be performed without this Authorization form.

******A photocopy of this authorization will be considered as effective and valid as the original******

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Facility or Home Health Questionnaire for patient referred for MBSS/VFSS

The following questionnaire is for the safety of all our patients and staff. Please answer the following questionnaire regarding each patient your facility has referred.

Facility name: _____; Patient Name: _____

1. Does your facility have current COVID-19 + patients, staff and/or cases under suspicion of COVID-19? ____yes. _____no

2. Has this patient been tested for COVID-19? ____yes. ____no. If yes, date_____, result_____.

3. If patient has tested positive for COVID-19 has there been 2 negative tests completed?
   - _____yes. _____ no. The most recent negative result must be within the week when the referral is sent.
   - Date for 1st negative result: _____.
   - Date for 2nd negative result: _____.
   - **Please attach most** recent negative result report.

4. Does this patient require other staff other than treating SLP to accompany patient (such as family member due to behavioral issues?) ___yes. ___no

5. Does the patient have any of the following symptoms:
   a. Fever __yes. ___no
   b. Cough __yes. ___no. If yes, is cough only with food/drink? ___yes. ___no
   c. Active PNA. ____yes. ___no. If yes, type diagnosed _____
   d. Loss of taste or smell ____yes. ___no
   e. Body Aches or chills. _____yes. ____no
   f. Diarrhea, nausea ____yes. ___no
   g. Recent contact with COVID-19+ patient, family or staff _____yes. ____no

6. Has the patient received vaccination?
   a) If Yes date of 1st dose_____ date of 2nd dose_____
   b) NO._____

MBS Imaging holds the right to hold or refuse to do the test if complete and accurate information has not been submitted by the facility**.**

_____ _____

Name and Title of personal filling this form. Date: