Case History and Order Form
Modified Barium Swallow (MBS)

- This form is to be completed and faxed **immediately after scheduling an MBS** to provide the Speech Pathologist performing the study with adequate history prior to patient's arrival.
  - For studies at York Hospital, please fax to: (717) 851-6203
  - For studies at Apple Hill Imaging Center, please fax to: (717) 812-3701

Patient's name: ______________________________ DOB:____________________________
Facility:______________________________________
Phone #_____________________________________ Fax #_____________________________

	Yes	No
Is the patient under the age of 15?		
Does the patient require special feeding tools or equipment?		
Is the patient over 300 pounds?		
Does the patient complain of food sticking below the collarbone?		
Does the patient have burning or reflux?		

History of present illness: ____

Past Medical History: ____

Indication for MBS: ☐ Dysphagia ☐ CVA ☐ Globus sensation ☐Odynophagia
☐ Laryngeal abnormalities ☐ Inhalation of food/vomitus

What is the patient's current diet consistency?
Solid: ☐ Regular ☐ Soft ☐ Fine-chopped ☐ Puree
Liquid: ☐ Regular/thin ☐ Nectar-thick ☐ Honey-thick
Non-oral: ☐ PEG/PEJ ☐ NGT ☐ TPN

Is the patient receiving swallowing therapy? ☐ Yes ☐ No If Yes, please explain:
____

Does the patient utilize any safe swallowing and/or compensatory strategies during meals?
☐ Yes ☐ No If yes, please explain:____

Did the patient have a recent MBS? ☐ Yes *date*:____________________ ☐ No
If yes, what were the results?____

Physician Signature ______________________________ Date______________________

Revised 2/2012