DDSN
Swallowing Disorders
CONSULTATION SUMMARY*

Name:_____

Residence:_____

Date of Birth:_____ Date:_____

Reason for Referral:

_____

_____

_____

Significant findings following review of submitted documentation:

_____

_____

_____

Assessment:

_____

_____

_____

Required Provider Follow-Up: *(Must occur within 30 calendar days of receipt of this summary [actions must be implemented immediately for those individuals residing in ICFs/IID] or documentation of justification for non-implementation must be available)*

_____

_____

_____

Should there be any questions or concerns regarding the required actions regarding this person's dysphagia/GERD status, please contact me at:_____.

_____ Date:_____

OT/SP

*Attach Related OT/SP Swallowing Evaluations