PHYSICIAN CERTIFICATION OF NECESSITY FOR FIBEROPTIC ENDOSCOPIC EVALUATION OF SWALLOWING (FEES)

During these unprecedented times, many nursing homes prefer to bring SDX FEES into their facility instead of exposing residents to external factors that are out of their control. With this and safety in mind as our #1 priority for our staff and for your residents, SDX will still perform onsite FEES following a pre-scheduling screening and with this completed physician certification of medical necessity.

BACKGROUND:

Both the American Speech-Language-Hearing Association and the American Academy of Otolaryngology-Head & Neck Surgery in conjunction with CMS guidance recommend postponing unnecessary endoscopic procedures. Those endoscopists performing even routine FEES procedures are at risk for exposure to a high viral load in the nasopharynx; thus, we will scope residents who are currently asymptomatic for COVID-19 and if previously COVID+, are 10 days post-symptom onset and 72 hours afebrile (when not taking fever reducer). In order to be eligible for an onsite FEES study, the physician or midlevel practitioner must complete this form. Forms MUST BE SUBMITTED VIA FAX or EMAIL to 1-877-522-8016 or Katrina@SDX-FEES.COM BEFORE THE SCHEDULED PROCEDURE. Any questions or concerns may be directed to Katrina at 860-573-0120. Thank you for your referrals.

FACILITY: ____

PATIENT NAME:_________________________________DOB: ___________ ROOM#________

PHYSICIAN or MIDLEVEL: PLEASE CHECK THE THREE (3) BOXES BELOW THAT APPLY TO THIS PATIENT.

☐ To the best of my knowledge, the patient named above is ASYMPTOMATIC for COVID-19.

or

☐ The above patient is under investigation for COVID-19 or is showing respiratory, neurological or gastrointestinal symptoms of unknown etiology.

☐ I do not believe that a FEES procedure is medically necessary at this time.

or

☐ I certify that a FEES procedure is medically necessary at this time for reasons including but not limited to this patient's risk for aspiration complications such as malnutrition, dehydration, respiratory compromise, choking or asphyxiation.

☐ This patient has NOT been tested for COVID.

or

☐ This patient most recently tested (RESULT)_______________ for COVID-19 on (date) _____________.
Please list other test results & dates for this patient. RESULT:____________ on (date)_____________.
RESULT:____________on (date)______________.

PHYSICIAN OR MIDLEVEL COMPLETING THIS CERTIFICATION: PLEASE PRINT NAME & SIGN BELOW:

CERTIFIED BY (PRINT NAME WITH CREDENTIALS):_______________________________________

SIGNATURE:____ DATE:_______________