Advanced Dysphagia Diagnostics, LLC

MOBILE FEES • THERAPY • CONSULTING • EDUCATION

Patient Consent Form

Background

Fiberoptic/Flexible Endoscopic Evaluation of Swallowing (FEES) is a procedure which utilizes modern technology to evaluate and manage swallowing difficulties. The procedure uses a flexible fiberoptic laryngoscope which is passed transnasally (slides in along the floor of the nose) to the hypopharynx (the back of the throat). At this point, the larynx and the surrounding structures can be viewed. The scope sits high in the throat, and does not pass between the vocal folds. Colored foods and liquids are given to the patient, and the swallow is viewed.

Possible adverse reactions as reported in the literature, which have been considered prior to this patient's selection:

1. Epistaxis (Nosebleed)
2. Vasovagal response (Fainting)
3. Laryngospasm (An abrupt tightening of the vocal folds IF the endoscope passes between the vocal folds)

I, _____, understand that a FEES has been ordered by my physician due to a concern of DYSPHAGIA. The procedure has been explained to me, including the potential adverse reactions. I give my consent for this evaluation and for the recording of this procedure. I understand that the recording and its images will be used for evaluation and treatment planning and may be used for education, research, and teaching or publication purpose, and if so utilized will be de-identified. I give my consent to the therapy provider to release any medical information necessary to process claims for this service, and I authorize my insurance company and/or Medicare to make payments on my behalf.

CONSENT GIVEN:

☐ **Written in person with one witness**

_____ Patient or patient representative _____ Date

_____ Witness _____ Date

OR

☐ **Verbal via Phone Contact with 2 witnesses**

_____ 1st witness _____ Date _____ Time

_____ 2nd witness _____ Date _____ Time