



DYSPHAGIA

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Southeast PA Regional Task Force

Eating, Drinking and Swallowing Checklist

Individual Name: _____ Date of Completion: _____

Instructions: The purpose of this checklist is to document information gathered about the eating, drinking and swallowing habits of the person you support. Please circle **Yes** or **No** for each item, and give the completed checklist to the person who coordinates medical care for the individual or the individual's primary care physician.

Type of setting where form is completed (i.e., home, day program, employment site, etc):

Challenging Eating & Drinking Habits: (consider behavioral supports if any are checked)

- Yes/ No Steals food
- Yes/ No Hides food
- Yes/ No Generally grabs food
- Yes/ No Takes in too much food and or liquid at one time (i.e., doesn't stop & take a breath or unable to limit bite/sip size) *
- Yes/ No Eats while moving around environment
- Yes/ No Eats with a tablespoon
- Yes/ No Excessive length of time to complete meal

Risky Swallowing & Eating Concerns

- Yes/ No Loss of food or drink out of mouth during or after meals
- Yes/ No Holding or pocketing food/liquids *
- Yes/ No Swallow foods whole *
- Yes/ No Inadequate chewing *
- Yes/ No Repeated attempts to swallow *
- Yes/ No Watery eyes/nose during or after eating
- Yes/ No Difficulty swallowing medication (i.e., unable to swallow large or multiple pills gags, spits out, pocket/hold pills in mouth) *
- Yes/ No Poor positioning risk factor (tilts head back/leans forward while eating and drinking)

- Yes/ No Episodes of coughing/choking during or after meals *
- Yes/ No Wet/gurgly voice during or after meals (if possible listen to the person say "ah" or vocalizing) *
- Yes/ No Increased congestion/secretions following meals *
- Yes/ No Excessive throat clearing *
- Yes/ No Increased temperature of an unknown cause (temperature spikes) *
- Yes/ No Frequent upper respiratory infections/pneumonia *

- Yes/ No Vomiting **
- Yes/ No Burping or indigestion (i.e., sour breath) **
- Yes/ No Weight loss **
- Yes/ No Regurgitation (during or following meals) **
- Yes/ No Complaint or indicate discomfort when swallowing **
- Yes/ No Shortness of breath while eating or drinking **

Other observations/comments: _____

Form completed by: _____ Title(s): _____

Others present: _____



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To Be Completed By The Person Coordinating Medical Care For The Individual (if applicable)

Living arrangement (i.e., home, residential agency, family living, etc): _____

Current diet/liquid level consistency: _____

Dentition (i.e., edentulous, dentures, etc): _____

Oral hygiene routine ___ independent? ___ dependent? ___ with assistance? Type of oral hygiene products used? (i.e., paste, mouth wash, toothbrush, swab, etc): _____

Any aspiration precautions/guidelines? Yes/ No

Any adaptive feeding equipment used? Yes/ No if yes, what type(s)?

Current or past diagnosis of dysphagia? Yes/ No

Current or past diagnosis of GERD? Yes/ No

Other medical/psychiatric diagnoses: (list all)

Current medications, list all including "over-the-counter": (attach list if necessary)

Form reviewed by: _____ Title(s): _____

Action Taken:

*Don't forget to include any issues noted in the ISP
Don't forget to take completed form to PCP @ Annual Physical*

<p>KEY: * indicates see PCP to consider possible tableside and/ or video swallow evaluation ** indicates see PCP for appropriate referral</p>
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