**SWALLOWING DISORDERS CHECKLIST**

NAME:

DOB:

Residence:

Male Female Provider Agency:

ICF CRCF CTH-I CTH-II SLP-I SLP-II

Other

# THOROUGHLY REVIEW INSTRUCTIONS BEFORE COMPLETING

Note: **YES** or **NO** for each statement and **CHECK ALL BOXES** that apply

|  |  |  |  |
| --- | --- | --- | --- |
| Year: Month/Day observed:  Current Weight: |  |  |  |
|  |  |  |
|  |  |  |
| 1. CHOKING INCIDENT with AIRWAY OBSTRUCTION. Incident Date:  *(Report in GER and as Critical Incident)*  Intervention required: Heimlich Back Thrusts Food/non-food Item: |  |  |  |
| 2. “CHOKING” type incident WITHOUT airway obstruction (no intervention required)  Incident date: Food/non-food Item: |  |  |  |
| 3. Coughs consistently: Before During or After meals |  |  |  |
| 4. Coughs at night while sleeping or when lying down Has morning hoarseness |  |  |  |
| 5. “Gets choked” or gags during meals.  Specific situations: |  |  |  |
| 6. Has documented progressive weight loss (planned or unplanned) or is noticeably under weight. Planned Unplanned |  |  |  |
| 7. Refuses or has difficulty with certain textures. (Liquids, grainy foods, chopped meats, etc.)  If yes, list Texture(s): |  |  |  |
| 8. Sounds wet or gurgly, when breathing or talking before, during or after eating/drinking Has excessive throat clearing |  |  |  |
| 9. Has frequent colds/respiratory illnesses Recurrent upper respiratory infections Consistent/ongoing congestion, or  Been diagnosed with PNEUMONIA in the last 12 months |  |  |  |
| 10. Multiple swallows are needed to clear mouth of food/liquid Holds food in mouth Pockets food in cheeks |  |  |  |
| 11. Requires extended time to complete meals. (>30 minutes for reasons other than socialization)  Describe: |  |  |  |
| 12. Eats at a fast pace Over packs mouth Swallows without adequate chewing, or Takes large bites off of whole food items (i.e., sandwiches, breads, cookies, etc.) |  |  |  |
| 13. Takes food/liquid from other consumers or has a history of this behavior. |  |  |  |
| 14. Refuses to eat or is eating less than they normally would. |  |  |  |
| 15. Vomits Regurgitates belches/burps during or after a meal.  How often? |  |  |  |
| 16. Engages in Hand Mouthing Behavior: During/after meals Throughout day |  |  |  |
| 17. Neck extension is observed during meals when eating/swallowing.  Describe: |  |  |  |

# IF ANY IEMS ARE SCORED “YES,” THE SWALLOWING DISORDERS FOLLOW-UP ASSESSMENT MUST ALSO BE COMPLETED.

1st Review Signature: Date: Phone#: Email:

2nd Review Signature: Date: Phone#: Email:

3rd Review Signature: Date: Phone#: Email:

535-13-DD Revised (11/30/17) Attachment B – Swallowing Disorders Checklist