

SWALLOWING AND FEEDING TEAM REFERRAL PLAN

Date form completed: _____

Student: _____ School: _____

Date of birth: _____ Classroom teacher: _____

Completed by/title: _____

Please check all that apply

MEDICAL INFORMATION

- repeated respiratory infections/history of recurring pneumonia
- received nutrition through tube feeding
- vocal cord paralysis
- cleft palate
- reported medical history of swallowing problems
- history of head injury
- weight loss/failure to thrive
- frequent constipation, diarrhea, or other GI tract problems

OBSERVED BEHAVIORS

- requires special diet or diet modification (i.e. baby foods, thickener, soft food only)
- poor upper body control
- poor oral motor functioning
- maintains open mouth posture
- drooling
- nasal regurgitation
- food remains in mouth after meals (pocketing)
- wet breath sounds and/or gurgly voice quality following meals or drinking
- coughing/choking during meals
- swallowing solid food without chewing
- effortful swallowing
- eyes watering/tearing during mealtime
- unusual head/neck posturing during eating
- hypersensitive gag reflex
- refusal to eat
- food and/or drink escaping from mouth or trach tube
- spitting up or vomiting associated with eating and drinking
- slurred speech
- meal time takes more than 30 minutes

Additional information or comments: _____

PARENT INPUT – FEEDING AND SWALLOWING

Student: _____ Date of birth: _____

Current height and weight: _____ Physician: _____

Allergies: _____

Does your student feed himself/herself? yes, independently yes, with assistance no

Does your student enjoy mealtime? _____

How do you know when your student is hungry? _____

How do you know when your student is full? _____

How long does it take your student to complete a meal?

- 10-20 min 20-30 min 30-40 min >60 min

Does your student have trouble with any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> choking during a meal | <input type="checkbox"/> breathing | <input type="checkbox"/> chronic ear infection |
| <input type="checkbox"/> chewing | <input type="checkbox"/> gurgly or "wet" voice | <input type="checkbox"/> gagging |
| <input type="checkbox"/> noisy breathing | <input type="checkbox"/> biting on utensils | <input type="checkbox"/> drooling |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> very fussy eating behaviors | |
| <input type="checkbox"/> tongue thrust | | |
| <input type="checkbox"/> coughing with or without spraying of food | <input type="checkbox"/> sensitive to being touched around the mouth | |
| <input type="checkbox"/> chronic respiratory problems | <input type="checkbox"/> drooling: <input type="checkbox"/> constant <input type="checkbox"/> frequent <input type="checkbox"/> occasional | |

Was or is your student fed through feeding tube? yes no

If yes, when? _____

Why? aspiration medication transition to oral feeding liquids only other

What are your student's food preferences?

Likes

Dislikes

What kinds of food does your child eat?

- | | | | |
|--|---------------------------------|--|--------------------------------------|
| <input type="checkbox"/> liquids | <input type="checkbox"/> pureed | <input type="checkbox"/> chopped | <input type="checkbox"/> table foods |
| <input type="checkbox"/> thickened liquids | <input type="checkbox"/> mashed | <input type="checkbox"/> bite-sized pieces | (whatever your family is eating) |
| | <input type="checkbox"/> ground | | |

Does your student take any nutritional supplements?

Yes No If yes, specify: _____

Do certain foods/liquids appear to be more difficult for your student to eat? _____

How is your student positioned during feeding?

- | | | | |
|---|--|-------------------------------------|--------------------------------|
| <input type="checkbox"/> sitting in a chair | <input type="checkbox"/> sitting in a wheelchair | <input type="checkbox"/> sitting | |
| <input type="checkbox"/> held on lap | <input type="checkbox"/> reclined | <input type="checkbox"/> lying down | <input type="checkbox"/> other |

What utensils are used?

- bottle spoon sippy cup cup (no lid) straw

Other adaptive equipment _____

Has your student ever had a swallow study? yes no If yes, when? _____

What were the results? _____

Additional comments or concerns: _____

Parent/guardian signature: _____ Date: _____

INTERDISCIPLINARY CONSULTATION SWALLOWING AND FEEDING OBSERVATION/EVALUATION

Date of consultation: _____

Student: _____ Age: _____ Date of birth: _____

Diagnosis: _____ Exceptionality: _____ Physician: _____

School: _____ Classroom teacher: _____

SLP: _____ OT: _____ Nurse: _____

Medical history: _____

GENERAL INFORMATION

During this consultation, the student was:

Seating: wheelchair Tumbleform Rifton chair other: _____

Student position: upright semi-upright reclining<30° other: _____

Food presented by: classroom teacher paraprofessional parent other: _____

Utensils used: bottle sippy cup cup spoon straw

GENERAL OBSERVATIONS

Behavior: cooperative resistant refusal other: _____

Alertness: alert lethargic irritable other: _____

Follows directions: verbal gestural none single step only

Visual impairment: mild impairment moderate impairment severe impairment

GENERAL PHYSICAL OBSERVATIONS

Abnormal reflexes observed: _____

Trunk: excessive extension dystonia scoliosis kyphotic asymmetric

Head control: adequate poor excessive head/neck hyper extension receives external positioning
 receives manual positioning reflexive position patterns

Facial: asymmetrical contortions jaw extension grimaces/tics
 open mouth posture increase tone decrease tone

Breathing patterns: mouth breather audible inhalation

OBSERVATION OF FEEDING

Food consistencies: pureed ground mashed chopped
 bite size mixed (indicate consistencies of mixtures)

Food presented during evaluation: _____

	Indicate food Consistency	Indicate observed behaviors	Additional observations
Accepts food			
Lips			
• poor lip closure			
• drooling			
• reduced lip action to clear material			
Tongue			
• poor bolus formation/movement			
• decrease anterior/posterior movement			
• food residue			
Absence of rotary jaw movement			
Munching jaw movement			
Delayed swallow initiation			
Swallow delay			
Cough following swallow			
• Increased clearing throat			
Residual food in oral cavity			
Cued swallow			
Fatigues easily			

OBSERVATION OF DRINKING

Liquid consistencies: unthickened nectar honey pudding

Liquid presented during evaluation: _____

	Indicate Liquid consistency	Indicate observed behaviors	Additional observations
Tongue thrust			
Reduced tongue retraction			
Anterior loss			
Limited jaw opening			
Limited upper lip closure over cup			
Delayed swallow			
Coughing following drink			

ADDITIONAL COMMENTS

RECOMMENDATIONS

- 1. _____
- 2. _____
- 3. _____
- 4. _____

INTERDISCIPLINARY CONSULTATION CONDUCTED BY

Speech/language pathologist

Occupational therapist

Nurse

ADDITIONAL PARTICIPANTS

Signature: _____

Title: _____

SWALLOWING AND FEEDING PLAN

Date of plan: _____

Review date: _____

Student: _____ Date of birth: _____

School: _____ Teacher: _____

Dysphagia Case Manager: _____

If there are any questions regarding this student's feeding plan, please contact the Case Manager at the following location(s) _____ Phone #: _____

Case history: _____

FEEDING RECOMMENDATIONS

Positioning: _____

Equipment: _____

Tube Fed: tube fed/nothing by mouth tube and oral fed
amount fed orally: _____

Diet/food prep

Food consistency: pureed ground chopped mashed bite sized

Liquid consistency: no liquids thin liquids

thickened liquids (circle): nectar honey pudding

Other: _____

FEEDING PLAN TECHNIQUES/PRECAUTIONS

Amount of food per bite: _____

Food placement: _____

Keep student in upright position _____ minutes after meal

Offer a drink after _____ bites

Additional precautions/comments: _____

SWALLOWING AND FEEDING PLAN IN SERVICE TRAINING

I, the undersigned, have read and been trained on implementing the swallowing and feeding plan for _____, I agree to follow the swallowing program as specified.

Name	Position	Date Review	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRE VFSS INFORMATION FORM

Name: _____ Date form completed: _____
Diagnosis: _____ Date of birth: _____
Referring SLP: _____ CA _____
Brief medical history _____

Positional concerns/adaptive equipment currently used at school: _____

Current diet: _____

SUMMARY OF INTERDISCIPLINARY CONSULTATION

The following was observed during a clinical observation of the student's feeding and swallowing at school.

Oral phase

- drooling
- pocketing: lateral sulcus anterior sulcus
- not clearing the oral cavity before swallow
- anterior loss/poor lip seal
- excessive chewing
- hyper/hypo sensitivity
- difficulty with bolus formation

Pharyngeal phase inferences

- coughing/choking: _____ before _____ after _____ during swallow
- delay in triggering swallow
- wet/gurgly voice quality after swallow
- decreased/absent laryngeal elevation
- expectorating food
- repetitive swallows

Information that the school system would like to get from the VFSS is as follows:

1. _____
2. _____
3. _____
4. _____

We have included a Tammany Parish School Board Authorization for Release of Confidential Information

SWALLOWING AND FEEDING TEAM PROCEDURE CHECKLIST

Student: _____ School: _____
 SLP: _____ OT: _____ Nurse: _____

PROCEDURE

DATE

Referral form completed and sent to Dysphagia Coordinator _____

Parent/Guardian informed of consent _____

Interdisciplinary consultation conducted _____

IEP meeting held (check attendance)

1. Person attending:

teacher

IEP facilitator

administrator

SLP

nurse

other: _____

OT

parent/guardian

2. Addressed at IEP (check issues addressed)

emergency plan

referral to physician

special diet

medical history

release of information

temporary feeding plan

Training is conducted (check and date)

_____ emergency plan

_____ feeding plan

Medical information/referral from physician is requested (check and date)

_____ clinical evaluation

_____ VFSS

Studies conducted (VFSS attended by case manager)

Diet prescription is sent to/received from physician

Diet order faxed to food service supervisor

School cafeteria manager and parent/guardian notified of diet order

Diet changes started at school

Therapy feeding guidelines and swallowing treatment plan developed

IEP reconvened to update information

School personnel and parent/guardians trained in feeding/treatment plan

Feeding/treatment plan initiated
