

How was the PRO administered? Individual completed independently Caregiver completed
 Clinician interviewed individual Clinician interviewed caregiver

NOMS Admission Patient-Reported Outcome (PRO) Form
Eating Assessment Tool (EAT-10)
Age Range: 18+

EAT-10 Instructions: These are statements that many people have used to describe the effect of swallowing problems on their lives. Mark the response that indicates how frequently you have the same experience. If proxy, please answer the following questions based on what you think your family member would say.					
Source: Belafsky, P.C. Mouadeb, D.A., et al. (2008). Validity and reliability of the Eating Assessment Tool. <i>Annals of Otology, Rhinology & Laryngology</i> , 117, 919-924.					
	0 No problem	1	2	3	4 Severe problem
My swallowing problem has caused me to lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My swallowing problem interferes with my ability to go out for meals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing liquids takes extra effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing solids takes extra effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing pills takes extra effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing is painful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The pleasure of eating is affected by my swallowing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I swallow food sticks in my throat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I cough when I eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing is stressful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Clinician Name: _____ Patient Name: _____ Facility: _____

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NOMS Discharge Patient-Reported Outcome (PRO) Form & Satisfaction Survey
Eating Assessment Tool (EAT-10)
Age Range: 18+

EAT-10 Instructions: These are statements that many people have used to describe the effect of swallowing problems on their lives. Mark the response that indicates how frequently you have the same experience. If proxy, please answer the following questions based on what you think your family member would say.					
Source: Belafsky, P.C. Mouadeb, D.A., et al. (2008). Validity and reliability of the Eating Assessment Tool. <i>Annals of Otolaryngology, Rhinology & Laryngology</i> , 117, 919-924.					
	0 No problem	1	2	3	4 Severe problem
My swallowing problem has caused me to lose weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My swallowing problem interferes with my ability to go out for meals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing liquids takes extra effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing solids takes extra effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing pills takes extra effort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing is painful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The pleasure of eating is affected by my swallowing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I swallow food sticks in my throat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I cough when I eat or drink.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing is stressful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Clinician Name: _____ Patient Name: _____ Facility: _____

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NOMS Discharge Patient-Reported Outcome (PRO) Form (continued)

NOMS Satisfaction Survey

<p>Instructions: Please tell us your thoughts about your swallowing. If proxy, please answer the following questions based on what you think your family member would say.</p> <p>Source: American Speech-Language-Hearing Association (2019). NOMS Satisfaction Survey.</p>					
	Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
I was involved in the planning and delivery of my treatment.	□	□	□	□	□
Because of speech-language pathology services, I have a better understanding of my swallowing problem.	□	□	□	□	□
Because of speech-language pathology services, I feel like my swallowing problem has improved.	□	□	□	□	□
Because of speech-language pathology services, I feel like I have the swallowing skills I need to participate in a variety of activities.	□	□	□	□	□

Clinician Name: _____ Patient Name: _____ Facility: _____