A. Preliminary Information

Reason for referral: _____
Chronological age (Adjusted age): _____
Primary caregiver: _____
Informant for evaluation: _____
Primary language: _____ ❒ Interpreter
Family concerns _____
❒ Barriers to learning: _____

B. Background Information

B1. Summary
Medical team (physicians, dentists, etc):
_____
_____
_____

Ancillary care team (nursing, therapists, etc):
_____
_____
_____

Previous Hospitalizations:
_____
_____
_____

Previous Surgeries:
_____
_____
_____

Medications:
_____
_____
_____

Allergies/Intolerances:
_____
_____
_____

Cultural preferences relevant to feeding:
_____
_____

B2. Birth History

❒ Complications during pregnancy: _____

Delivery:

❒ Vaginal ❒ Cesarean-section: (reason) _____

❒ Single Birth ❒ Multiple Birth: (define) _____

❒ Complications during delivery: _____

❒ Term ❒ Preterm: _____(weeks/days)

❒ NICU: (describe) _____

Birth weight: _____

❒ APGAR Scores: ____ @ 1m, ____ @ 5 m, ____ @ 10 m

B3. ❒ Congenital malformations, deformations, and chromosomal abnormalities

Details including treatment: _____

_____

B4. ❒ Conditions/Disorders/Diseases of the nervous system

Details including treatment: _____

_____

B5. ❒ Conditions/Disorders/Diseases of the circulatory system

Details including treatment: _____

_____

B6. ❒ Conditions/Disorders/Diseases of the respiratory system

Details including treatment: _____

_____

B7. ❒ Conditions/Disorders/Diseases of the digestive system

Details including treatment: _____

_____

B8. ❒ Conditions/Disorders/Diseases of the musculoskeletal system and connective tissue

Details including treatment: _____

_____

B9. ❒ Neoplasms

Details including location of neoplasm & treatment: _____

_____

B10. ❒ Mental, behavioral, and neurodevelopmental disorders

Details including treatment: _____

_____

B11. ❒ Injury, poisoning and other consequences of external causes
Details including treatment: _____
_____

B12. ❒ Hearing impairment: _____

B13. ❒ Visual impairment: _____

B14. ❒ Diagnostic procedures completed (dates & results)
- ❒ MBS/VFSS: _____
- ❒ FEES: _____
- ❒ pH/Impedance probe: _____
- ❒ Upper GI: _____
- ❒ Gastric emptying/Milk Scan: _____
- ❒ Other: _____

B15. Swallowing/Feeding & Nutrition History

❒ Breastfeeding:

_____

❒ Bottle feeding:

_____

❒ Spoon from caregiver:

_____

❒ Fingers (self):

_____

❒ No spill cup:

_____

❒ Straw:

_____

❒ Utensils (self):

_____

❒ Open cup:

_____

❒ Alternate feeding methods (tube feeding, parenteral nutrition, etc…)

_____

Historically, child consumes adequate amount and variety of:

			Comment if No
Liquids	❒ Yes	❒ No	
Fruits	❒ Yes	❒ No	
Vegetables	❒ Yes	❒ No	
Grains	❒ Yes	❒ No	
Dairy	❒ Yes	❒ No	
Meats	❒ Yes	❒ No	

History of:

❒ Dehydration
❒ Poor Weight Gain
❒ Coughing/choking during or after eating/drinking
❒ Gagging/vomiting during or after eating/drinking
❒ Wet vocal quality during or after eating/drinking
❒ Problematic behaviors during or after eating/drinking

Details: _____
_____
_____
_____

C. Evaluation Information

Number of meals/snacks offered each day: _____
Average length of meal/snack times: _____
❒ Routine for meal/snack times: _____
Typical position for feeding: _____
Fed by: ❒ Self ❒ Others: _____
❒ Sensory preferences: _____
❒ Modifications to food or fluid: _____
❒ Use of additives or supplements: _____

Before assessment:

State: _____ Respiratory Rate: _____
Oxygen saturation: _____ Pain Assessment: _____

Assessment

Oral Motor/Peripheral

All structures observed ❒ Yes ❒ No
List structures not observed: _____
All structures within expected limits for age, sex, race: ❒ Yes ❒ No
Details if no: _____
Movement patterns, tone, and reflexes are appropriate for age
❒ Yes ❒ No
Details if no: _____

Non-Nutritive Suckling/Sucking: ❒ Not applicable ❒ Adequate
❒ Impaired
Describe: _____

Oral sensory response
❒ Functional ❒ Signs of hypersensitivity ❒ Signs of hyposensitivity
Describe: _____

Adequate secretion management: ❒ Yes ❒ No
Describe if no: _____

Phonation: ❒ Functional ❒ Impaired ❒ Not applicable (i.e. trach)
Describe if impaired: _____

Signs of stress during assessment: ❒ Yes ❒ No
Describe if yes: _____

Oral Feeding
Position(s) during feeding: _____

❒ Pureed foods trialed: _____
Fed by: ❒ Self ❒ Caregiver ❒ Clinician
Spoon feeding skills were appropriate for age: ❒ Yes ❒ No
Details if no: _____
Compensatory strategies trialed: _____
Results of compensatory strategies: _____

❒ Solid foods trialed: _____
Fed by: ❒ Self ❒ Caregiver ❒ Clinician
Biting/chewing skills were appropriate for age: ❒ Yes ❒ No
Details if no: _____
Compensatory strategies trialed: _____
Results of compensatory strategies: _____

❒ Liquids trialed: _____
Fed by: ❒ Self ❒ Caregiver ❒ Clinician
Drank from: ❒ Lidded cup ❒ Straw ❒ Open cup
❒ Bottle ❒ Other: _____
Drinking skills were appropriate for age: ❒ Yes ❒ No
Details if no: _____
Compensatory strategies trialed: _____
Results of compensatory strategies: _____

❒ Concern for pharyngeal phase dysfunction: _____
❒ Concern for esophageal phase dysfunction: _____
❒ Disruptive feeding behavior: _____
Oral sensory response:
❒ Functional ❒Signs of hypersensitivity ❒Signs of hyposensitivity
Comments: _____

After assessment:
State: _____ Respiratory Rate: _____
Oxygen saturation: _____ Pain Assessment: _____
Other observations: _____

D. <u>Clinical Summary</u>
(Patient name) is a (age) (gender) that presents with (functional/dysfunctional) oral feeding skills characterized by _____.
Prognosis for safe oral intake: ❒ Good ❒ Fair ❒ Poor
Prognosis for adequate oral intake: ❒ Good ❒ Fair ❒ Poor
Strengths: _____
Concerns: _____

Diagnosis/ICD10:

- ❒ Dysphagia, unspecified R13.10
- ❒ Dysphagia, oral phase R13.11
- ❒ Dysphagia, oropharyngeal phase R13.12
- ❒ Other: _____

Recommendations:

- ❒ Continue oral feeding, no modifications
- ❒ Continue oral feeding with the following modifications: _____
  _____
- ❒ Instrumental evaluation of swallow function
  - ❒ MBS/VFSS ❒ FEES
  - ❒ Other: _____
- ❒ Feeding therapy (see plan of care)
- ❒ Refer to
  - ❒ Registered dietitian ❒ Gastroenterologist
  - ❒ Pulmonologist ❒ Developmental pediatrician
  - ❒ Other: _____
- ❒ Additional recommendations: _____
  _____
  _____

Plan of care:

Speech therapy intervention (is/ is not) recommended for (number of times/ week) for (time of session, such as 30 minutes) as tolerated for at least (number of weeks/months). Interventions include but are not limited to the following:

_____

Long term goals: _____

_____

Short term goals: _____

_____

- ❒ Education provided to family regarding results, recommendations, and plan.
- ❒ Barriers to learning: _____
- ❒ Family demonstrated understanding of results, recommendations, and plan.
- ❒ Reinforcement needed: _____