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:
_____________________________________________________________________________________________

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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, ____ @ 5m, ____ @ 10m

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: _______________________________________

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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...)

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Pediatric Feeding History and Clinical Assessment Template (Liquid, Pureed, Solid)

<table>
<thead>
<tr>
<th>Historically, child consumes adequate amount and variety of:</th>
<th>Comment if No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liquids</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Fruits</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Vegetables</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Grains</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Dairy</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Meats</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

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: ___________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

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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: ____________________________

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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. Clinical Summary
(Patient name) is (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: __________________________________________________________

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### 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: _______________________

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