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, ___ @ 5 m, ___ @ 10 m

B3. ☐ Congenital malformations, deformations, and chromosomal abnormalities
Details: _______________________________________________________
______________________________________________________________

B4. ☐ Conditions/Disorders/Diseases of the nervous system
Details: _________________________________________________________
______________________________________________________________

B5. ☐ Conditions/Disorders/Diseases of the circulatory system
Details: _________________________________________________________
______________________________________________________________

B6. ☐ Conditions/Disorders/Diseases of the respiratory system
Details: _________________________________________________________
______________________________________________________________

B7. ☐ Conditions/Disorders/Diseases of the digestive system
Details: _________________________________________________________
______________________________________________________________

B8. ☐ Conditions/Disorders/Diseases of the musculoskeletal system and
connective tissue
Details: _________________________________________________________
______________________________________________________________

B9. ☐ Neoplasms
Details: _________________________________________________________
______________________________________________________________

B10. ☐ Mental, behavioral, and neurodevelopmental disorders
Details: _________________________________________________________
______________________________________________________________

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B11. □ Injury, poisoning and other consequences of external causes
Details: ____________________________
______________________________

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:

□ Other:

□ Alternate feeding methods (tube feeding, parenteral nutrition, etc...)

History of:
□ Dehydration
□ Poor Weight Gain
□ Coughing/choking during or after drinking
□ Gagging/vomiting during or after drinking
□ Wet vocal quality during or after drinking
□ Pain/discomfort during or after eating/drinking
Details: ____________________________
______________________________
______________________________

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C. **Evaluation Information**
- Bottle & Type of fluid: ____________________  
- Breast
- Average number and length of feedings: ____________________
- People who feed infant: ____________________
- Position(s) for feeding: ____________________
- Volume (daily intake):  
  - Formula: ____  
  - Expressed breast milk: ____
- Sensory preferences: ____________________
- Infant drinks other fluid from bottle (i.e. water): ____________________
- Modifications to 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:**  
- Adequate  
- Impaired  
- Not assessed
- 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:**
- Feeding position: ____________________
- Length of time spent feeding: _____
Pediatric Feeding History and Clinical Assessment Template (Liquids Only)

Liquids trialed: ___________________________________________________________
Fed by: □ Self □ Caregiver □ Clinician
Drank from: □ Breast □ Bottle □ Other: ____________
Sucking/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: ____________________________

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 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

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Plan of care:
Speech therapy intervention (is/ is not) recommended for (number of times/ week) for (time of sessions, 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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