UNM SCHOOL of MEDICINE

Continuum of Care

Aspiration Clinical Team Screening Tool -- For G-tube Fed Individuals (NPO)

SECTION I	BASIC INFORMATION	
NAME:	**Date:**	**Region:**
Address: **Phone #:**	**DOB:**	**SSN:**
CASE MGR: **Agency:** **E-Mail:**	**Phone:**	**Fax:**
Guardian:	**Phone:**	
PCP:	**Phone:**	**Fax:**
Residential Agency:	**Phone:**	**Fax:**
Agency Nurse:	**Phone:**	**Fax:**
Day Agency:	**Phone:**	**Fax:**
Service Coordinator:	**Phone:**	**Fax:**
Health Care Coordinator:	**Phone:**	**Fax:**
Speech/Language Pathologist (SLP):	**Phone:**	**Fax:**
Occupational Therapist (OT):	**Phone:**	**Fax:**
Physical Therapist (PT):	**Phone:**	**Fax:**
Dietician:	**Phone:**	**Fax:**

SECTION II	MEDICAL DIAGNOSIS/PROBLEMS

SECTION III	ALLERGIES (Medications, Food, Latex & Environment)

SECTION IV	MEDICATION LIST	

SECTION V	MEDICATION ADMINISTRATION		
Whole pills ☐	Sprinkles ☐	Crushed with Medium ☐	Liquid ☐

SECTION VI	PLANS (answer Yes, No, or NA)		
PLAN ↓	**PRESENT ↓**	**REVIEWED ↓**	**LAST UPDATED ↓**
Tube Feeding Protocol	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
Healthcare/Nursing Care Plan	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
SAFE Report	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
Positioning Plan/Instruction	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
Community Program Review	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
Crisis Prevention/ Intervention Plan	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
ISP	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
MAR	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
Oral Hygiene Plan/Instructions	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
Nutritional Assessment	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	
PT Support Plan	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	

SECTION VII	TRAINING DOCUMENTATION

SECTION VIII	NUTRITION AND DIETARY PLAN
Last Weight:	
Minimum weight last 6 months :	Date
Maximum weight last 6 months :	Date
Special Diet/Dietary Needs (special formula, diet, consistency, etc.,):	

SECTION IX	HISTORY OF
Aspiration Pneumonia: Y ☐ N ☐	Date:
Other respiratory illnesses:	
Hospitalizations:	

Check all that apply:

Cough ☐	Choking ☐	Wheezing ☐	Fever ☐	Rumination ☐	GERD ☐
Vomiting ☐	Constipation ☐	Drooling ☐	Seizures ☐	Scoliosis ☐	Spasticity ☐
Throat clearing: ☐	Belching ☐		Aerophagia ☐	Bruxism ☐	
Abnormal Movements: ☐			Difficulty With Head Control: ☐		

Suctioning Needed: ☐	Frequency:
Oxygen Requirements: ☐	liters/minute
Neb Treatments: ☐	
Usual Level of Alertness: Alert ☐ Aware ☐ Easily Agitated ☐ Sleepy/Lethargic ☐ Semi-Conscious ☐ Unresponsive ☐	
Swallow Study: Y ☐ N ☐	Date (if known):
Upper GI Study: Y ☐ N ☐	Date (if known):

SECTION X	**ORAL HYGIENE**		
Toothbrush ➔	Electric: ☐	Manual: ☐	Suction: ☐
Method Used ➔	Independent: ☐	Dependent: ☐	Hand over Hand: ☐
Do They Use ➔	Toothette: ☐	Toothpaste: ☐	Mouthwash: ☐
Missing Teeth ☐	Dentures: ☐	Partials: ☐	Do they wear: ☐

How does the Individual tolerate tooth brushing?	Well ☐	Coughs ☐
Resistant ☐	Gags ☐	Bites Toothbrush ☐
Other (Describe):		

SECTION XI	**CHALLENGING BEHAVIORS THAT PRESENT AN EATING RISK (If Applicable)**
1. Does the Individual seek food?	
2. Does the Individual grab for food?	
3. Does the Individual hoard or hide food?	
4. Does the Individual mouth non-food items?	
5. Is there a history of pica?	
8. Does the Individual become agitated associated with feedings?	
9. If any challenging behaviors are present, can the Individual be redirected?	

SECTION XII	POSITIONING	
1. What are the positioning guidelines for: • Tube feedings: • Medication Administration: • Personal care: • Sleep : • Leisure:		
2. Does Individual use a wheelchair?	Yes ☐	No ☐
3. Does positioning appear to be supported by current wheelchair?	Yes ☐	No ☐
a) If "NO," is a seating/positioning consultation recommended?	Yes ☐	No ☐

SECTION XIII	Questions for staff administering Tube feedings and/or medications
1. Have you been trained on the Tube Feeding Protocol?	
2. Do you understand the Tube Feeding Protocol?	
3. What type of food, liquid or Formula does the Individual receive through the Tube?	
4. Does the Individual receive anything by mouth?	
5. How long does it take to complete the feeding?	
6. Where are you during the Individual's feeding?	
7. Where does the Individual take his/her medication?	
8. How does the Individual receive water?	

SECTION XIV	TUBE FEEDING		
Type of Tube:		Date Inserted (if known):	Date Last Changed:
Type of Feeding	Drip ☐ Gravity ☐ Bolus ☐ Pump☐ Rate	Other	
What is the current formula: Amount		Frequency	
Any problems with Tube Feedings:			

SECTION XV	NARRATIVE DESCRIPTION of observations during feeding

SECTION XVI	SUMMARY EVALUATION Part 1		
PLAN	**Present/Consistent/ Implemented ↓**	**Needed ↓**	**Needs Revision ↓**
Tube Feeding Protocol ➔			
HCP for aspiration /dysphagia ➔			
CPIP ➔			
Oral hygiene instructions ➔			
Positioning instructions➔			
Nutritional Assessment➔			

SUMMARY EVALUATION Part 2		
1	Tube Feeding Protocol (TFP) is individualized and appropriate to the person's needs:	Yes ☐ No ☐ See Recommendations ☐
2	TFP is implemented appropriately by caregiver:	Yes ☐ No ☐ See Recommendations ☐
3	Is the Crisis Prevention /Intervention Plan (CPIP) individualized and appropriate to meet the person's needs:	Yes ☐ No ☐ See Recommendations ☐
4	Is the Health/Nursing Care Plan (HCP) individualized and appropriate to meet the person's needs:	Yes ☐ No ☐ See Recommendations ☐
5	Does the Individual and/or guardian agree with the TFP: a.) If #5 is No, is there a Decision Justification Form completed to document the process undertaken by the IDT?	Yes ☐ No ☐ See Recommendations ☐ Yes ☐ No ☐ See Recommendations ☐
6	Is Technical Assistance (TA) needed to develop an appropriate and adequate Tube Feeding Protocol? If "YES," TA to address TFP will be provided by: DDSD CSB: ☐ ACT SLP: ☐ IAA: ☐ Other:	Yes ☐ No ☐ See Recommendations ☐

SECTION XVII	STRENGTHS

SECTION XVIII	FINDINGS AND RECOMMENDATIONS
1	**Finding**: **Recommendation(s):**
2	**Finding**: **Recommendation(s):**
3	**Finding**: **Recommendation(s):**
4	**Finding**: **Recommendation(s):**

Staff that attended screening: **Date:**

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