UNM SCHOOL of MEDICINE

Continuum of Care

Aspiration Clinical Team Screening Tool -- For Oral Feedings

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		

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

SECTION VI	PLANS (answer Yes, No, or NA)		
PLAN ↓	**PRESENT ↓**	**REVIEWED ↓**	**LAST UPDATED ↓**
Mealtime Plan	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 Rvw	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:

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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

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?	
6. Does the Individual gulp his/her food or drink?	
7. Is there a rapid rate of eating?	
8. Does the Individual become agitated associated with eating?	
9. If any challenging behaviors are present, can the Individual be redirected?	

SECTION XII TUBE FEEDING (If Applicable)

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 XIII Questions for staff administering oral feedings and/or medications

1. Have you been trained on the Mealtime Plan?	
2. Do you understand the Mealtime plan?	
3. Are there any special guidelines for setting up the Individual's meal (i.e. cues, ½ the meal given at a time so they can have seconds, special positioning, etc)?	

4. How do you prepare the Individual's food/liquids?	
5. Where are you positioned during feeding (in relation to the Individual)?	
6. What adaptive equipment/tools are needed to assist with feeding?	
7. Does the Individual appear to enjoy eating?	
8. Where does the Individual take his/her medication?	
9. How does the Individual take his/her medication?	

SECTION XIV POSITIONING

1. What are the positioning guidelines for:
   - Oral 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 XV NARRATIVE DESCRIPTION of observations during feeding

SECTION XVI EATING & ORAL MOTOR ABILITY – SLP OBSERVATION

Food Consistency	Comments/Describe
☐ Regular	
☐ Chopped/Mechanical	
☐ Ground	
☐ Soft	
☐ Blended to Consistency	
Liquids	

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☐ Regular	
☐ Thickened to consistency	
☐ Temperature	
Eating Equipment	
☐ Regular	
☐ Adapted	
Eating Behaviors	
☐ Eats Orally	
☐ Feeds Self Independently	
☐ Co-Actively	
☐ Finger – Feeding	
☐ Appropriate bite size	
☐ Appropriate pace	
☐ Drinks Independently	
☐ Drinks Co-actively	
Time needed to complete meal	
Position during eating:	
% of eating that is monitored for safety:	
☐ Referral for positioning Technical assistance:	
Achieved Lip Closure:	
☐ Over Cup	
☐ Over Straw	
☐ Over Spoon	
☐ While chewing	
☐ While swallowing	
Sucking	
☐ Liquid from cup rim	
☐ Liquid from straw/spout	
☐ Food from spoon	
Swallowed Liquid:	
☐ Without Coughing	
☐ Without Loss	
Swallowed Food:	
☐ Without coughing	
☐ Without Loss	
☐ Mouth Cleared Following	
☐ Ate without drooling	
☐ Appeared to be timely	
Jaw and Tongue Mobility	
Describe jaw position at rest	
☐ Opened jaw for food (smoothly, graded, coordinated)	
☐ Functional chew	
☐ Chewing movements	

Signs/Symptoms of Aspiration while eating			
Coughing: ☐ productive ☐ non-productive	Primarily on: ☐ solids ☐ liquids ☐ Frequency:		
☐ Red face	☐ Tearing eyes	☐ Runny nose	
☐ Choking	Primarily on: ☐ solids ☐ liquids ☐ Frequency: ☐ need for assistance		
☐ Fatigue	☐ decrease rate	☐ diminished interest	☐ refusal to continue
☐ Gagging	☐ during meal	☐ after meal	
☐ Increased Saliva Production	☐ during meal	☐ after meal	
☐ Belching	☐ during meal	☐ after meal	
☐ Throat Clearing	☐ during meal	☐ after meal	

SECTION XVII SUMMARY EVALUATION Part 1

PLAN	Present/Consistent/ Implemented ➔	Needed ➔	Needs Revision ➔
Mealtime Plan ➔			
HCP for aspiration /dysphagia ➔			
CPIP ➔			
Oral hygiene instructions ➔			
Positioning instructions➔			
Nutritional assessment ➔			
Other health related plans ➔			

SUMMARY EVALUATION Part 2

1	Meal Time Plan (MTP) is individualized and appropriate to the person's needs:	Yes ☐ No ☐ See Recommendations ☐
2	MTP is implemented appropriately by caregiver:	Yes ☐ No ☐ See Recommendations ☐
3	Is the Crisis Prevention 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 MTP: a.) If #5 is No, is there a Decision Justification Form completed to document the process undertaken by the IDT?	Yes ☐ No ☐ Info unavailable ☐ See Recommendations ☐ Yes ☐ No ☐ See Recommendations ☐
6	Is Technical Assistance (TA) needed to develop an appropriate and adequate Meal Time Plan? If "YES," TA to address MTP will be provided by: SAFE Clinic: ☐ DDSD CSB: ☐ ACT SLP: ☐ IAA: ☐ Other:	Yes ☐ No ☐ See Recommendations ☐

SECTION XVIII STRENGTHS

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

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Staff that attended screening: **Date:**

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