Student's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are your main eating concerns?**

**Medical Care**

**Diagnosis/Health Concerns:**

**Physicians:**

**Date of last medical exam:**

**Release of information** (for medical provider) □ No □ Yes

**Has the student had previous surgeries? (Clarify date, surgeon, purpose)**

* Gastrostomy
* Ilestomy/Colostomy
* Pacemaker
* Shunt
* Tracheostomy
* Fundal Plication/Nissen Fundoplication
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has the student had a previous Safe Eating Evaluation?** □ No □ Yes if yes, date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of information** (for provider who performed previous Safe Eating Evaluation) □ No □ Yes

**Barium Swallow** □ No □ Yes **Parent has copies of study** □ No □ Yes

**Communication Patterns** □ Typical □ Non-Verbal □ Short Phrases (list specifics below) □ Signs

**Eating At Home**

**Dietary/GI:**

* Poor appetite
* Difficulty swallowing
* Choking
* Absent gag reflex
* Difficult chewing
* Refuses to eat new food textures
* Failure to gain weight or poor weight gain
* Reflux/vomiting and or spitting up during/after meals
* Fussy after meals

# Meals/ day \_\_\_\_\_\_\_ Eats small frequent meals: Times \_\_\_\_\_\_\_\_\_\_\_\_

# Snacks/ day \_\_\_\_\_\_\_ Length of meal/snack times \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Supplement.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food Preparation:**

□ Dependent □ Needs some assistance (specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

□ Cut food into small bites □ Blend all food

Liquids: □ Thin □ Thickened, what consistency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Thickener used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Positioning during eating \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Positioning after eating \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Adaptations:**

* Uses cup – specify type\_\_\_\_\_\_\_\_\_\_\_
* Uses fork
* Uses knife
* Uses spoon – amount per spoonful \_\_\_\_\_\_
* Drinks from straw
* Squirt bottle
* Bottle
* Special chair and/or table

**Gastrostomy tube:** □ Present □ Past

If feeding tube in past, but orally now, procedures used to transition:

**Respiratory:**

□ **Ventilation/respiratory support** [ ] Past [ ] Present Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **History of aspiration**  If yes, when/how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **Noisy gurgling respirations-phonations before, during or after feeding**

□ **Cannot control oral secretions** □ **Foul or sour breath odor** □ **History of oral thrush**

**Other**:

**Mobility**

* Limited ROM movement patterns
* Paralysis
* Needs special transfer technique
* Position restriction/dislikes (list below)

**Self-Feeding Skills**

**What utensils does the student use when feeding themselves?**

□ Spoon □ Fork □ Cup □ Bottle □ Straw

**What cues/prompts does the student need frequently while feeding themselves?**

□ Mouth too full □ Stay on task □ Bite size □ Portion control

**Does the student need assistance with set up?** □ Opening containers □ Cutting food

**Parent Reported Behavioral Observations While Feeding/Drinking**

* Coughing, gagging, choking
* Heimlich or intervention required
* Drooling
* Gurgling during & following swallow
* Arches back into hyperextension during/after feeding
* Tires easily, need small frequent feedings
* Turns head to side during and after feeding
* Loses liquid/food from mouth
* Multiple swallows
* Poor food lateralization
* Difficulty coordinating breathing/swallowing
* Emesis/vomiting

**Other Parental Concerns:**

RN Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_