A. Identifying information

Patient name: _____
DOB: _____Age: _____
Referring physician: _____
Primary Diagnosis: _____
Primary caregiver (s):_____
Reason for referral:

_____
_____
_____

Patient accompanied by: ☐ Parent 1 ☐ Parent 2 ☐ Legal guardian ☐ Other: _____
Primary language: ☐ English ☐ Spanish ☐ Other: _____
Interpreter needed:☐ Yes ☐ No

B. Pertinent past and current medical information

B1. Prenatal/birth history

Length of pregnancy (weeks): _____
Were there any complications during pregnancy or delivery? ☐ Yes ☐ No
If yes, please explain:

_____
_____

Birth Weight_____ Apgar Scores_____

Twin: ☐ Yes ☐ No If yes: ☐ Identical ☐ Fraternal
Multiple: ☐ Yes ☐ No If yes: please indicate number _____

B2. Hospitalization/surgical history

Date(s):
_____Facility_____
Reason (s) for hospitalization:

_____
_____

Date(s):
_____Facility_____
Reason (s) for hospitalization:

_____
_____

Additional Hospitalizations:

_____
_____

B3. Known precautions/allergies
Medical allergies: ☐ Latex ☐ Other: _____
Food allergies: ☐ Dairy ☐ Gluten ☐ Nuts ☐ Soy ☐ Other: _____
Does your child require an EpiPen for any allergies? ☐ Yes ☐ No
Food intolerances: ☐ Dairy ☐ Gluten ☐ Nuts ☐ Soy ☐ Other: _____
Comments: _____

B4. Current Medications ☐ Not applicable
Medication 1:_____How long been taking?_____
Prescribed for: _____
Medication 2:_____How long been taking? _____
Prescribed for:_____
Medication 3:_____ How long been taking?_____
Prescribed for:_____
Additional Medications:
_____

B5. Neurologic History/Current Concerns ☐ Not applicable
HISTORY of neurologic deficits? ☐ Yes ☐ No
If yes, please check: ☐ abnormal muscular tone (high) ☐ abnormal muscular tone (low) ☐ Anoxia ☐ Ataxia ☐ Brain tumor ☐ Hydrocephalus ☐ Microcephaly ☐ Paralysis ☐ Seizures
☐ Stroke ☐ TIAs ☐ Tremor ☐ Other: _____
If any box checked, please explain:
_____
_____
Has your child ever had any brain imaging studies done? ☐ Yes ☐ No
If yes, **when** was the testing, **where** was the testing completed, and **what** were the results?
_____
_____

CURRENT neurologic status**:** ☐ No problems ☐ Current issue(s) ☐ Regular follow-up with neurologist (physician name) _____
☐ Regular follow-up with pediatrician for neurologic issues: (physician name, unless previously provided) _____
If current issues, please explain: _____
_____

B6. Cardiac History/Current Concerns ☐ Not applicable
HISTORY of heart problems? ☐ Yes ☐ No
If yes, please indicate the specific heart problem or suspected problem:

_____
_____

Please check if any of the following **have** occurred: ☐ Surgery ☐ Episodes of cyanosis
☐Altered activity level ☐ Intolerance of specific positions secondary to cardiac condition

Known complications from cardiac condition: ☐ CVAs ☐ TIAs ☐ Vocal fold paralysis
☐ Other _____ If any box checked, please explain: _____
_____

CURRENT cardiac status**:** ☐ No problems ☐ Current issue(s) ☐ Regular follow-up with cardiologist (physician name) _____
☐ Regular follow-up with pediatrician for cardiac issues: (physician name, unless previously provided) _____

If current issues, please explain: _____

B7. Respiratory History/Current Respiratory Concerns ☐ Not applicable
HISTORY of respiratory problems: (check all that apply)
☐ Apnea (Obstructive) ☐ Apnea (Central) ☐ Asthma ☐ Bronchitis/bronchiolitis
☐ Bronchopulmonary Dysplasia (BPD) ☐ Malacia (broncho) ☐ Malacia (laryngo)
☐ Malacia (tracheo) ☐ Nasal/Chest Congestion ☐ Pneumonia ☐ Tracheal stenosis
☐ Wheezing ☐ Other: _____

If pneumonia, how many times? ___
Was it ever classified as aspiration pneumonia? ☐ Yes ☐ No
If yes, please explain: _____
Approximate number of colds per year (circle): normal above average
Approximate number of upper respiratory infections per year: _____

Tracheostomy tube? ☐ Yes ☐ No
If yes (history of tracheostomy tube), please answer the following: Reason for trach AND length of time child had the trach _____
Complications related to the trach (granuloma tissue build-up, etc.): ☐ Yes ☐ No
If yes, please explain: _____
_____

Does your child have a **history** of any respiratory support (excluding surgeries)? Circle all that apply**:**
Ventilator BiPap CPAP Supplemental oxygen Other
If yes, please explain: _____
_____
Most recent scope, type of scope (E.g. bronchoscopy; endoscopy), date and results:
_____
_____
_____

CURRENT respiratory status (check all that apply): ☐ No problems ☐ Current issues
☐ Regular follow-up with ENT: (physician name)
_____
☐ Regular follow-up with pulmonary: (physician name)_____
☐ Regular follow-up with respiratory therapist: (therapist name)_____
☐ Regular follow-up with pediatrician: (physician name, unless previously provided)_____

If child has CURRENT issues/needs select from the following: ☐ Asthma ☐ CPAP/BiPAP
☐ Congestion (chest) ☐ Congestion (nasal) ☐ Pneumonia ☐Supplemental O_2
☐ Tracheostomy ☐ Ventilator Use ☐ Wheezing ☐ Other: _____
Please explain: _____
_____
Provide **current respiratory treatment** regarding daily breathing treatments and if child has emergency plan in place (i.e. inhalers) ☐ None ☐ Yes, If yes, please explain:
_____
Does your child attend daycare? ☐ Yes ☐ No

If child **currently** has a TRACH please answer following questions:
Does your child also require mechanical ventilation? ☐ Yes ☐ No
CPAP/BiPAP? ☐ Yes ☐ No
If yes, please explain: _____
_____
Supplemental oxygen? ☐ Yes ☐ No; If yes, volume/amount _____
Anticipated Length of time child will have trach? _____
Size of tube: _____Manufacturer: _____
Tolerance of speaking valve/plugging: _____
Frequency of suctioning:☐ Rarely ☐ Occasionally ☐ Sometimes ☐ Frequently ☐ Other

Viscosity of secretions: ☐ Normal ☐ Change in viscosity
If a change in viscosity, please describe? _____
Color of secretions? ☐ Clear ☐ Not Clear
If not clear, please describe? _____
Does food or liquid come out of the trach? ☐ Yes ☐ No, If yes please describe (i.e. food, liquid, both, timing related to oral intake _____
_____

B8. Gastrointestinal History/Current Gastrointestinal (GI) Concerns ☐ Not applicable
HISTORY of GI deficits? ☐ Yes ☐ No

If yes, check all that apply ☐ Altered peristalsis ☐ Bowel obstruction ☐ Crohn's Disease ☐ Chronic diarrhea ☐ Constipation ☐ Dehydration ☐ Diabetes ☐ esophagitis (Eosinophilic) ☐ Esophagitis (general) ☐ Failure to thrive ☐ GI bleeding ☐ Hypoglycemia ☐ Reflux
☐ Slow gastric emptying ☐ Short bowel syndrome ☐ Vomiting ☐ Other: _____
If yes, please provide additional notes: _____

HISTORY of GI surgery: ☐ Yes ☐ No
If yes, check all that apply: ☐ Colostomy ☐ Fundoplication ☐ Pylorotomy ☐ Short gut ☐Other:_____
If yes, please explain: _____
_____
_____
Did your child ever receive any alternative feeds? ☐ Yes ☐ No

If yes, please select (all that apply): ☐ NG-tube ☐ G-tube ☐ J-tube ☐ PEG tube ☐ PEJ tube
☐ TPN ☐ Other: _____
Type of feeding received: ☐ Bolus ☐ Continuous drip ☐ Combination ☐ Other

Has your child ever had any of the following tests completed?
☐ MBS ☐ FEES study ☐ Upper GI ☐ Barium Swallow ☐ pH probe ☐ Sialogram
☐ Other: _____
If so, please indicate the dates and results of tests. If multiple tests completed only provide the most recent on the lines below _____
_____
Early oral feeding trials: Chronology of formulas (if child less than 3, please indicate all formulas trialed/utilized) and any comments on poor tolerance: _____
_____

CURRENT GI status (check all that apply): ☐ No problems ☐ Current issues ☐ Regular follow-up with gastroenterology (physician name)

_____

☐ Regular follow-up with pediatrician for GI issues: (physician name, unless previously provided) _____

Do you or your doctor have concerns about recent weight gain or weight loss: ☐ Yes ☐ No
If yes, please explain _____
Has your child ever had a nutritional consult? ☐ Yes ☐ No
If yes, please provide the name of consultant and date last visited with any pertinent comments

Has your child ever had blood tested to determine nutritional deficits? ☐ Yes ☐ No
If yes, please provide date of most recent testing and results

_____

If your child currently has reflux, have you ever noted coughing or a "gurgly" voice after the episode? ☐ Yes ☐ No
If your child currently suffers from recurrent vomiting, approximately how many times daily do they vomit? _____
Is your child currently receiving tube feeds? ☐ Yes ☐ No
If yes, what Type? ☐ NG-tube ☐ PEG tube ☐ PEJ tube ☐ G-tube ☐ J-tube ☐ Other:

_____

Current rate: _____
Current schedule: _____
Additional current GI issues, please explain: _____

_____

B9. Renal History/Current Renal Concerns ☐ Not applicable

HISTORY of renal problems? ☐ Yes ☐ No
If yes, check (all that apply):☐ Acute renal failure ☐ Chronic renal failure ☐ Dialysis
☐Structural deviations ☐ Related Surgeries ☐ Other: _____
If yes, please explain: _____
CURRENT renal status (check all that apply): ☐ No problems ☐ Current issues ☐ Regular follow-up with nephrology: (physician name) _____
☐ Regular follow-up with pediatrician: (physician name, unless previously provided)

_____

If current issues, please explain: _____
Does your child **currently** have food/fluid restrictions due to renal problems (i.e. protein, potassium, sodium, fluid, calcium, and phosphorous intake). ☐ Yes ☐ No
If yes, please explain in detail: _____

_____

B10. Craniofacial history/Current Craniofacial Concerns ☐ Not applicable

HISTORY: Has your child ever had any known defects of the lip and/or palate? ☐ Yes ☐ No
If yes, please explain: _____
Does your child have a diagnosed syndrome, association, or sequence? ☐ Yes ☐ No
If yes, please explain: _____
History of sinus infections? ☐ Yes ☐ No
History of resonance pattern deficits? ☐ Yes ☐ No
History of surgical repair(s)
If yes or want to add additional comments, please provide below:

_____

_____

CURRENT craniofacial status (check all that apply): ☐ No problems ☐ Current issues
☐ Regular follow-up with genetics (physician name)
_____
☐ Regular follow-up with plastic surgery (physician name)
_____
☐ Regular follow-up with ENT (physician name)
_____
☐ Regular follow-up with pediatrician: (physician name, unless previously provided)
_____

Do you ever notice food or liquid coming out of the nose? ☐ Yes ☐ No
If yes, please select:
Frequency? ☐Every meal ☐Daily ☐Weekly ☐ Occasionally ☐ Rarely ☐ Other:_____
Type of consistency? ☐ Thin Liquids ☐ Thick liquids ☐ Puree ☐ Solids
With straw use? ☐ Yes ☐ No
Position(s) of the child? _____
If additional current problems, please explain:

_____

_____

B11. Dental History/Current Dental Concerns
HISTORY Has your child ever been to the dentist? ☐ Yes ☐ No
Most recent dental visit and results:

_____
Has your child ever had dental surgery or any unusual dental findings? ☐ Yes ☐ No
If yes, please explain: _____
CURRENT dental status (check all that apply): ☐ No problems ☐ Current issues ☐
Regular follow-up with dentist:(dentist name)

_____
☐ Regular follow-up with orthodontist (orthodontist name)

_____

Does your child have normal dentition (number/placement of the teeth)? ☐ Yes ☐ No
If yes to either of the previous questions, please explain:

_____

_____

Are your child's teeth currently brushed daily? ☐ No ☐ Yes
By whom? ☐ Child ☐ Parent/caregiver ☐ Other: _____
Reaction to tooth brushing: ☐ Enjoys ☐ Resists ☐ Other: _____
If selected "resists" or "other", please explain:

_____

_____

Additional issues, please explain:

_____

_____

B12. Hearing & Vision History / Current Hearing & Vision Concerns
Hearing: HISTORY hearing loss confirmed with formal testing? ☐ Yes ☐ No
If yes, what were the findings? ☐ WFL ☐ Impaired ☐ Unknown If impaired, please explain and include remediation plan (i.e. aids, cochlear implants):

_____

_____

CURRENT hearing/chronic ear infection status (check all that apply): ☐ No problems
☐ Current issues ☐ Regular follow-up with pediatrician: (physician name, unless previously provided)

_____

☐ Regular follow-up with ENT:(physician name, if not previously provided)

_____

☐ Follow-up with audiologist: (audiologist name, if not previously provided)

_____

If current issues please explain:

_____

Vision: HISTORY of vision problems? ☐ Yes ☐ No
If yes what were the findings? ☐ WFL ☐ Impaired ☐ Unknown
If impaired, select from the following: ☐ Cortical visual impairment ☐ Ptosis ☐ Strabismus ☐ Other: _____ If box checked, please explain (affected eye(s), restrictions, etc.)

_____

_____

Current vision status (check all that apply): ☐ No problems ☐ Current issues ☐ Regular follow-up with ophthalmologist: (physician name)

_____

☐ Regular follow-up with pediatrician for visual issues: (physician name, unless previously provided)

Does your child currently use any adaptive vision equipment? ☐ Yes ☐ No

If yes, select the type of adaptive equipment: ☐ Glasses ☐ Patch ☐ Other

If selected, provide details: _____

If any additional issues, please explain: _____

B13. Before leaving medical history are any additional medical specialists involved with child (check all that apply): ☐ Dermatology ☐ Psychiatry ☐Psychology ☐ Other_____

If yes, please provide physician name(s): _____

C. Developmental Milestones

C1. Current speech/communication skills

Current main mode(s) of communication (select all that apply): ☐ Gestures ☐ Vocalizations ☐ Speech ☐ AAC ☐ Other _____:

If using speech, please rate speech skills: ☐ Within age appropriate limits ☐ Delayed ☐ Impaired

If delayed or impaired please explain:

_____

Is your child regularly being followed by speech-language pathologist? ☐ Yes ☐ No

If yes, please provide the name of the SLP therapist/location:

_____

C2. Cognition

Has your child ever been tested for an inability to sit still, pay attention, remember things, or learn like other children his/her age? ☐ Yes ☐ No

If yes, has a formal diagnosis been given? ☐ ADD ☐ ADHD ☐ Autism spectrum ☐ Other: _____

If no, do you have any concerns in any of these areas? ☐ Yes ☐ No

If yes, please explain: _____

(If school age) Learning disabilities: ☐ Yes ☐ No

If yes, please explain: _____

Is your child regularly being followed by an educational specialist? ☐ Yes ☐ No

If yes, please provide the name of specialist/school: _____

C3. Current gross motor skills

☐ WFL ☐ Delayed ☐ Impaired

If delayed or impaired, please check all that apply:

☐ Head control ☐ Trunk control ☐ Tone ☐ Mobility ☐ Other_____

Please explain:

_____

Is your child regularly being followed by physical therapist? ☐ Yes ☐ No

If yes, please provide the name of the therapist:

_____

C4. Current fine motor skills

☐ WFL ☐ Delayed ☐ Impaired

If delayed or impaired, please explain:_____

Is your child regularly being followed by occupational therapist? ☐ Yes ☐ No

If yes, please provide the name of the therapist: _____

C5. Current Sensory Skills

☐ WFL ☐ Impaired

If impaired: ☐ Hypersensitive ☐Hyposensitive ☐ Other:_____

If impaired, please explain_____

Is your child regularly being treated for these sensory issues? ☐ Yes ☐ No

If yes, please provide name of therapist (if different from above)

_____

C6. Current Nutritional Status/Feeding History/Responses to Food/Current Skills

a. Current oral feeds volume: ☐ Exclusive (all nutrition received by mouth)
☐Partial supplementation with tube ☐ "Tastes" (for pleasure/stimulation/exposure) ☐N/A

b. For LIQUIDS, please answer the following questions:

Does your child require the liquids to be thickened? ☐ Yes ☐ No

If yes, please indicate degree liquids are thickened and recipe used:

_____

If yes, please indicate the length of time your child has been on thickened liquids:

_____

Does your child CURRENTLY take any liquids orally that do not have to be thickened? ☐ Yes

☐No If no, and never did, please go to section on smell and taste (page 13).

Otherwise please answer the following questions.

First took/used			Current Use		
1. Breast	☐N/A	Age: _____	Takes/uses now? ☐ Yes	☐No	If no, age stopped: ___
2. Bottle	☐N/A	Age: _____	Takes/uses now? ☐ Yes	☐No	If no, age stopped: ___
3. No-spill cup	☐N/A	Age:_____	Takes/uses now? ☐ Yes	☐No	If no, age stopped: ___
4. Straw	☐N/A	Age:_____	Takes/uses now? ☐ Yes	☐No	Comment:_____
5. Open cup	☐N/A	Age:_____	Takes/uses now? ☐ Yes	☐No	Comment:_____
6. Other	☐N/A	Age:_____	Takes/uses now? ☐ Yes	☐No	Comment:_____

How many ounces of fluid does your child consume daily? _____

Does your child ever cough or choke with liquids? ☐Yes ☐No

Does your child ever sound gurgly while drinking or immediately after? ☐Yes ☐No

If yes, please comment:

_____

_____

Please select the types of liquid that is regularly consumed:

☐ Water ☐ Breastmilk ☐ Formula ☐ Milk ☐Juice ☐ Soda ☐ Yogurt drinks

☐Other: _____

Comment on any preferences of a specific brand of nipple or cup:

_____

Comment on any position:

_____

For FOODS, please answer the following questions:

Does your child **CURRENTLY** take any foods orally? ☐ Yes ☐No If no, and never did, please go to section on smell and taste (page 13) Otherwise please answer the following questions.

First took/used			Current Use		
1. Spoon (by caregiver)	☐N/A	Age:_____	Now? ☐ Yes	☐No	Comment:_____
2. Fingers (by caregiver)	☐N/A	Age:_____	Now? ☐ Yes	☐No	Comment: _____
3. Utensils (self)	☐N/A	Age:_____	Now? ☐ Yes	☐No	Comment:_____
4. Fingers (self)	☐N/A	Age:_____	Now? ☐ Yes	☐No	Comment:_____
6. Other	☐N/A	Age:_____	Now? ☐ Yes	☐No	Comment:_____

How many ounces of food (approximately) does your child orally consume daily?_____

Does your child ever cough or choke with food? ☐Yes ☐No

Does your child ever sound gurgly while eating or immediately after? ☐Yes ☐No

If yes, please comment:
_____
_____

Please select the types of food consistency (select all that apply) that is regularly consumed:

☐ Thin puree (e.g. baby food apricots) ☐ Puree (e.g. pudding) ☐ Dissolvable solids (e.g. puffs)

☐ Soft solids (e.g. cheese, raisins) ☐ Hard solids (e.g. cookies, dry cereal)

☐ Multiple consistencies (e.g. dry cereal with milk)

☐ Difficult to chew foods (e.g. meat, raw vegetables) ☐ Other_____

Does your child require any specialized feeding equipment? ☐ Yes ☐No If yes please comment_____
_____

Please select the **variety** of foods that your child will eat

Fruits: ☐None ☐1-2 ☐3-4 ☐ More than 5
Comment:_____
Vegetables ☐None ☐1-2 ☐3-4 ☐ More than 5
Comment:_____
Grains ☐None ☐1-2 ☐3-4 ☐ More than 5
Comment:_____
Dairy ☐None ☐1-2 ☐3-4 ☐ More than 5
Comment:_____
Meats ☐None ☐1-2 ☐3-4 ☐ More than 5
Comment:_____

Do you or your doctor have any concerns regarding the variety of foods that your child will eat?
☐Yes ☐No

If yes, please comment _____

Would you consider your child to be a “picky” eater? ☐ Yes ☐ No

Does your child prefer foods that are: ☐Room temperature ☐Hot ☐Cold

Smell and Taste

Smell: ☐ WFL ☐ Unknown ☐ Heightened ☐ Diminished
Taste: ☐ WFL ☐ Unknown ☐ Heightened ☐ Diminished
Preference: ☐ Sweet ☐ Salty ☐ Bitter ☐ Sour ☐ Strong flavors ☐ Other: _____

Would you say that your child gags easily with different foods? ☐ Yes ☐ No
If yes, please explain: _____
Do you prepare special meals? ☐ Yes ☐ No
If yes, how many meals per day? _____
Do you feel you to have play games to distract your child to get them to eat? ☐ Yes ☐ No
If yes, how frequently do you have to use this distraction? _____
Do you feel you have to reward the child to get them to eat? (i.e. airplane game, clapping, bubbles) ☐ Yes ☐ No
If yes, how frequently are the rewards used? _____
Do you notice a difference in how much your child eats or how long they stay engaged based on who may be feeding them or different environments? ☐ Yes ☐ No
If yes, please explain: _____

Meal time routines and introduction of new foods:

1. What are the number of planned meals/snacks your child receives daily? _____
2. How long are mealtimes in general (period of time where your child is engaged in eating)?
☐ < 5 minutes ☐ 5-20 minutes ☐ 30-45 minutes ☐ over 45 minutes
3. Does your child eat at the same time and place as the family? ☐ Yes ☐ No
4. What type of chair does your child sit in for most meals at home?

☐ No Chair ☐ High Chair ☐ Adapted chair ☐ Booster seat ☐ Regular "kitchen" chair
☐ No one place, multiple chairs/surfaces ☐ Other: _____

4. Does your child stay seated for the meal time? ☐ Yes ☐ No

If no, approximately how long will the child sit and eat? _____

Place an **X** on the following line indicate where your child falls on the continuum:

_____

(Always)Feeds independently **Caregiver feeds completely**

D. ASSESSMENT (CLINICIAN OBSERVED OR ELICITED)

D1. Postural control (muscle tone and movement pattern):

Mobility: Appropriate for age? ☐ Yes ☐ No

If no, please explain:

_____

Tone: ☐ Normal ☐ Hypotonic ☐ Hypertonic ☐ Fluctuating

If not normal describe:

_____

Movement patterns: ☐ Symmetric ☐ Asymmetric ☐ Dyskinesia

Reflexes: Age appropriate reflexes (e.g. gag, swallow) ☐ present ☐ Absent

(Note which are

absent_____)

☐ If any reflexes persist that should have been suppressed, please indicate which ones:

☐ ATNR ☐ Startle ☐ Bite ☐ Suckle ☐ Rooting ☐ Other: _____

Head control: ☐ WFL ☐ Impaired ☐ Utilization of specialized equipment ☐ Other

Trunk control: ☐ WFL ☐ Impaired ☐ Utilization of specialized equipment ☐ Other

Comments (if impaired, comment here):

_____

D2. Oral motor/peripheral:

Direct assessment of firm pressure tolerance (sensory processing) during the oral mechanism examination:

Please check any box for a strong rejection reaction of the following areas: ☐ Outer cheeks

☐ Lips ☐ Gums ☐ Internal cheeks ☐ Hard palate ☐ Tongue

If any boxed checked please describe the observed reaction, length of time reaction continued, any external /self-calming techniques utilized

_____

If any of the above areas were not able to be assessed, please circle

Structural observations:

Face: Symmetry (overall): ☐ WFL ☐ Right side reduced ☐ Left side reduced

Facial expressions: ☐ WFL ☐ Other:

Jaw: (Structure and general movement) ☐ WFL ☐ Micrognathic ☐ Retrognathic

☐ Asymmetric ☐ Limited movement ☐ Increased movement ☐ Other: _____

Lips: Structure: ☐ WFL ☐ Cleft ☐ Right droop ☐ Left droop ☐ Other _____

Movement in general ☐ age appropriate ☐ Good ☐ Fair ☐ Poor ☐ Absent

Tongue: Structure ☐ WFL ☐ Microglossia ☐ Macroglossia ☐ Cleft ☐ Asymmetric ☐ Short frenulum ☐ Fasciculations

Grooving/cupping of tongue to finger (dry spoon) ☐ Absent ☐ Present ☐ Unable to assess

Lateralization on command: ☐ Absent ☐ Present Bilaterally ☐ Present Unilaterally

If unilateral: ☐ Movement right only ☐ Movement to the left only

Lateralization with cue: ☐ Absent ☐ Present Bilaterally ☐ Present Unilaterally

If unilateral: ☐ Movement right only ☐ Movement to the left only

Type of cue used: ☐ Visual ☐ Tactile ☐ Other: _____

Resting Tongue position:

☐ WFL ☐ Retracted ☐ Bunched ☐ Protruded ☐ Elevated ☐ Flat

Cheeks: ☐ WFL ☐ Increased tone ☐ Decreased tone

Teeth: ☐ WFL for age (number and place) ☐ Missing teeth ☐ Extra teeth ☐ Misplaced teeth ☐ Underbite ☐ Overbite ☐ Crossbite ☐ Poor molar surface contact on R ☐ Open bite ☐ Poor molar surface contact on L **Condition:** ☐ Damaged/broken teeth ☐ Decayed ☐ Other:_____

Palate: ☐ WFL ☐ High/narrowed/arched ☐ Cleft (repaired/unrepaired) ☐ Submucosal cleft (repaired/unrepaired)

Voice: Quality ☐ WFL ☐ Hoarse ☐ Harsh ☐ Breathy ☐ Gurgly ☐ Other:_____

Pitch ☐ WFL ☐ High ☐ Low for age

Resonance: ☐ WFL ☐ Hypernasal ☐ Hyponasal

Cough (unrelated to food presentation): ☐ WFL ☐ Frequent ☐ Productive ☐ Non-productive ☐ Delayed ☐ Did not assess/observe

Secretion management ([1]☐ WFL ☐ Age appropriate ☐ Impaired

If impaired, note: Frequency: ☐ Seldom ☐ Variable ☐ Often ☐ Constant

Volume: ☐ 0, Absent ☐1, Mild ☐ 2, Moderate ☐ 3, Severe ☐ 4, Profuse

Respiratory status during assessment (prior to feeding):

Respiratory patterns at baseline:

☐ Normal, easy work of breathing ☐ Increased work of breathing

Audible inspiration? ☐ Yes ☐ No

Supra or sub sternal retractions? ☐ Yes ☐ No

Breaths per minute (BPM) at rest: _____

Other: _____

Comments:

Oral Feeding Assessment:

A. Feeding position (observed in session):

☐ Prone ☐ Supine ☐ Side-lying ☐ Standing ☐ Other: _____

☐ Sitting: If sitting, select ☐ Independent ☐ Supported ☐ Adaptive equipment

Was this position typical for this child? ☐ Yes ☐ No

If no, please explain: _____

B. **Foods** trialed during the assessment (pre-swallow assessment)

Food given	Reaction normal	Hypersensitive	Hyposensitive	Reaction (+ or -):			
				Texture	Taste	Temperature	Color

C. Were foods given from a spoon/utensil? ☐ Yes ☐ No If no, skip to mastication section

If yes, type of spoon/utensil used _____

Did the child anticipate the utensil approaching the mouth? ☐ Yes ☐ No

Did the child open their mouth willingly? ☐ Yes ☐ No

Did the child need cuing to open their mouth? ☐ Yes ☐ No, If yes, describe:

_____

Did the child clean the utensil with their lips? ☐ Yes ☐ No; If no, how did you get the bolus in the mouth? _____

Did the child require any support of the mandible to close the mouth? ☐ Yes ☐ No

Did you place the utensil on the tongue? ☐ Yes ☐ No; If no please explain:

_____

Did the child need to be paced? ☐ Yes ☐ No

Did the child attempt to self-feed with the utensil? ☐ Yes ☐ No

If yes, was the child consistently successfully getting the food into the mouth? ☐ Yes ☐ No

Comment on any unexpected findings from spoon feeding:

_____
_____
_____

C. Were foods given that required biting off a piece? ☐ Yes ☐ No If no, skip to mastication section

Did the child need assistance from the clinician/parent? ☐ Yes ☐ No If yes, please explain:

_____

Was the child able to bite off a piece that was appropriate size? ☐ Yes ☐ No

Did the child demonstrate awareness of bite size? ☐ Yes ☐ No

Did the child have the strength to bite through the food? ☐ Yes ☐ No

Does the child bite through the food with the front teeth? ☐ Yes ☐ No, If no, describe:

_____

Did the child keep the food that was bitten off in the mouth? ☐ Yes ☐ No; If no, please explain_____

Did the child attempt to masticate the food? ☐ Yes ☐ No If no, did the child swallow the bite whole? _____

Did the child require any support of the mandible to bite the food? ☐ Yes ☐ No

Did the child tend to bite more effectively on one side versus another? ☐ Yes ☐ No

If yes, please explain:_____

Comment on any unexpected findings from observing biting foods:

_____

_____

C. Were foods given that required mastication? ☐ Yes ☐ No If no, skip to liquids section

Did the child need assistance from the clinician/parent getting the masticated food into the mouth? ☐ Yes ☐ No If yes, please explain: _____

Was the child able to chew with varying size boluses? ☐ Yes ☐ No If no, please explain: _____

Did the child demonstrate awareness of bolus size? ☐ Yes ☐ No

Did the child close their lips during chewing? ☐ Yes ☐ No

Did the child lateralize the bolus to the molar surface? ☐ Yes ☐ No, If not indicate how the child got the bolus to the molars (i.e. fingers) _____

Did the child demonstrate a chew? ☐ Yes ☐ No

If yes, was it more ☐ up/down or ☐ rotary ☐ Other

If no, please explain_____

Did the child keep the food in their mouth while chewing? ☐ Yes ☐ No; If no, please explain_____

Did the child tend to chew more effectively on one side versus another? ☐ Yes ☐ No

If yes, please explain: _____

Did the child demonstrate any of the following: ☐ pocketing in right cheek ☐ pocketing in left cheek ☐ pocketing in both cheeks ☐ poor bolus formation ☐ gagging while manipulating the bolus ☐ Swallowing before bolus is fully chewed ☐ Holding of food

Comment on any unexpected findings from observing chewing foods:

_____

_____

D. Were liquids given? ☐ Yes ☐ No If no, skip to next section

If yes, how was the liquid delivered? ☐ Bottle ☐ Sippy cup (no spill) ☐ Open cup ☐ Straw ☐ Other _____

Did the child anticipate the vessel approaching the mouth? ☐ Yes ☐ No

Did the child open their mouth willingly? ☐ Yes ☐ No

Did the child need cuing to open their mouth? ☐ Yes ☐ No

If yes, describe _____

Did the child need assistance from the clinician/parent? ☐ Yes ☐ No

If yes, please explain: _____

Was the child able to take a volume that was appropriate size? ☐ Yes ☐ No

Did the child demonstrate awareness of volume size? ☐ Yes ☐ No

Did the child have any anterior loss of the bolus? ☐ Yes ☐ No

Did the child demonstrate: ☐ single swallow ☐ consecutive swallows ☐ both

Did the child demonstrate tongue protrusion (i.e. stick the tongue out of the mouth during the swallow? ☐ Yes ☐ No

Did the child bite on the nipple or lid of cup? ☐ Yes ☐ No

Comments:

_____

E. Pharyngeal phase

☐ No overt signs/symptoms of pharyngeal phase problems
☐ Signs/symptoms of pharyngeal phase problems:
☐ Coughing ☐ Throat clearing ☐ "Wet" vocal quality ☐ Multiple swallows
☐ Effortful swallowing ☐ Delay
Please indicate consistencies on which the pharyngeal symptoms were observed
Comments:_____

Esophageal phase

☐ No overt signs/symptoms of esophageal phase problems
☐ Signs/symptoms of esophageal phase problems indicating need for referral to physician
Comments: _____

Other Observations noted during study

Were changes in respiration observed? ☐ Yes ☐ No

Were endurance issues observed? ☐ Yes ☐ No If yes, please explain

Changes of alertness were observed during the assessment? ☐ Yes ☐ No

Comments: _____

Behavior: ☐ Cooperative and attentive ☐ Participation impacted (note in comments)

Comments: _____

Family Education

Family goals include: _____

_____

Plan reviewed w/patient/family? ☐ Yes ☐ No

Family in agreement with plan? ☐ Yes ☐ No

Education provided to family? ☐ Yes ☐ No

Family demonstrated understanding? ☐ Yes ☐ No

☐ Reinforcement needed ☐ Disagrees with recommendation after counseling

Educational supports identified: ☐ Yes ☐ None

☐ Denial ☐ Need interpreter ☐ Cultural ☐ Other

Comments: _____

Clinical summary:

Impression:

Feeding status (check all that apply): ☐ Oral ☐ Non-oral ☐ Transitioning to full oral
Dysphagia type and severity: ☐Oral: ☐ WFL ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
☐ Pharyngeal: ☐ No concerns ☐ Suspect problems
☐ Esophageal: ☐ No Concerns ☐ Suspect problems ☐ Medically managed? ☐ Yes ☐ No
If yes, how effective is the medical management?

_____

***Potential risk of aspiration*:** ☐ High ☐ Moderate ☐ Fair ☐ Minimal ☐ Appropriate for developmental age
Prognosis for safe oral intake: ☐ Good ☐ Fair ☐ Poor

Volume of oral intake: ☐ Age Appropriate ☐ Reduced-no supplementation needed
☐ Reduced-requires partial supplementation ☐ Poor-requires complete supplementation

***Prognosis for adequate volume of oral intake*:** ☐ Good ☐ Fair ☐ Poor
Variety of Oral intake: ☐ Age Appropriate ☐ Restricted ☐ Severely restricted
Prognosis forage appropriate variety of oral intake: ☐ Good ☐ Fair ☐ Poor

Specific impairment:_____
Specific symptoms:_____
Strengths: _____
Weaknesses/concerns: _____

Diagnosis/ICD9:
☐ Feeding Problems in Newborns 779.31 ☐ Feeding Difficulties 783.3
☐ Failure to Thrive 783.41 ☐ Oral Phase Dysphagia 787.21
☐ Oropharyngeal Dysphagia 787.22 ☐ Pharyngeal Dysphagia 787.23
☐ Other:
Plan of care:☐ Modified Barium Swallow Study ☐ Fiberoptic Endoscopic Evaluation of Swallowing

Outpatient feeding therapy **to begin now**: ☐ No ☐ Yes (continue to goals below)

☐ Determination for OP feeding therapy **deferred** based on further evaluation(s)(skip to referral)
Long term goals:

_____

_____

Short term goals:

_____

_____

Consideration of referral to additional specialist(s) for further assessment:

_____

_____

References:

[1]Crysdale, W.S. & White, A. (1989). Submandibular duct relocation for drooling: A 10-year experience with 194 patients. Otolaryngology-Head and Neck Surgery, 101, 87-92.