SWALLOWING AND FEEDING TEAM REFERRAL PLAN

Date form completed:_____

Student:_____ School:_____

Date of birth: _____ Classroom teacher:_____

Completed by/title:_____

Please check all that apply

MEDICAL INFORMATION

- ☐ repeated respiratory infections/history of recurring pneumonia
- ☐ received nutrition through tube feeding
- ☐ vocal cord paralysis
- ☐ cleft palate
- ☐ reported medical history of swallowing problems
- ☐ history of head injury
- ☐ weight loss/failure to thrive
- ☐ frequent constipation, diarrhea, or other GI tract problems

OBSERVED BEHAVIORS

- ☐ requires special diet or diet modification (i.e. baby foods, thickener, soft food only)
- ☐ poor upper body control
- ☐ poor oral motor functioning
- ☐ maintains open mouth posture
- ☐ drooling
- ☐ nasal regurgitation
- ☐ food remains in mouth after meals (pocketing)
- ☐ wet breath sounds and/or gurgly voice quality following meals or drinking
- ☐ coughing/choking during meals
- ☐ swallowing solid food without chewing
- ☐ effortful swallowing
- ☐ eyes watering/tearing during mealtime
- ☐ unusual head/neck posturing during eating
- ☐ hypersensitive gag reflex
- ☐ refusal to eat
- ☐ food and/or drink escaping from mouth or trach tube
- ☐ spitting up or vomiting associated with eating and drinking
- ☐ slurred speech
- ☐ meal time takes more than 30 minutes

Additional information or comments:_____

_____

_____

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PARENT INPUT – FEEDING AND SWALLOWING

Student:_____ Date of birth:_____
Current height and weight:_____ Physician:_____
Allergies:_____
Does your student feed himself/herself? ☐ yes, independently ☐ yes, with assistance ☐ no
Does your student enjoy mealtime?_____
How do you know when your student is hungry?_____
How do you know when your student is full?_____
How long does it take your student to complete a meal?

☐ 10-20 min ☐ 20-30 min ☐ 30-40 min ☐ >60 min

Does your student have trouble with any of the following?

- ☐ choking during a meal
- ☐ chewing
- ☐ noisy breathing
- ☐ vomiting
- ☐ tongue thrust
- ☐ breathing
- ☐ gurgly or "wet" voice
- ☐ biting on utensils
- ☐ very fussy eating behaviors
- ☐ chronic ear infection
- ☐ gagging
- ☐ drooling
- ☐ coughing with or without spraying of food
- ☐ chronic respiratory problems
- ☐ sensitive to being touched around the mouth
- ☐ drooling: ☐ constant ☐ frequent ☐ occasional

Was or is your student fed through feeding tube? ☐ yes ☐ no
If yes, when?_____
Why? ☐ aspiration ☐ medication ☐ transition to oral feeding ☐ liquids only ☐ other
What are your student's food preferences?

Likes	Dislikes

What kinds of food does your child eat?

- ☐ liquids
- ☐ thickened liquids
- ☐ pureed
- ☐ mashed
- ☐ ground
- ☐ chopped
- ☐ bite-sized pieces
- ☐ table foods (whatever your family is eating)

Does your student take any nutritional supplements?
☐ Yes ☐ No If yes, specify:_____
Do certain foods/liquids appear to be more difficult for your student to eat?_____
_____
How is your student positioned during feeding?

- ☐ sitting in a chair
- ☐ held on lap
- ☐ sitting in a wheelchair
- ☐ reclined
- ☐ sitting
- ☐ lying down
- ☐ other

What utensils are used?

☐ bottle ☐ spoon ☐ sippy cup ☐ cup (no lid) ☐ straw

Other adaptive equipment_____
Has your student ever had a swallow study? ☐ yes ☐ no If yes, when?_____
What here the results?_____
_____
Additional comments or concerns:_____
_____
Parent/guardian signature:_____ Date:_____

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INTERDISCIPLINARY CONSULTATION SWALLOWING AND FEEDING OBSERVATION/EVALUATION

Date of consultation:_____

Student:_____ Age:_____ Date of birth:_____

Diagnosis:_____ Exceptionality:_____ Physician:_____

School:_____ Classroom teacher:_____

SLP:_____ OT:_____ Nurse:_____

Medical history:_____

_____

_____

GENERAL INFORMATION

During this consultation, the student was:

Seating: ☐ wheelchair ☐ Tumbleform ☐ Rifton chair ☐ other: _____

Student position: ☐ upright ☐ semi-upright ☐reclining<30° ☐ other:_____

Food presented by: ☐ classroom teacher ☐ paraprofessional ☐ parent ☐ other:_____

Utensils used: ☐ bottle ☐ sippy cup ☐ cup ☐ spoon ☐ straw

GENERAL OBSERVATIONS

Behavior: ☐ cooperative ☐ resistant ☐ refusal ☐ other: _____

Alertness: ☐ alert ☐ lethargic ☐ irritable ☐other:_____

Follows directions: ☐ verbal ☐ gestural ☐ none ☐ single step only

Visual impairment: ☐ mild impairment ☐ moderate impairment ☐severe impairment

GENERAL PHYSICAL OBSERVATIONS

Abnormal reflexes observed:_____

Trunk: ☐ excessive extension ☐ dystonia ☐ scoliosis ☐ kyphotic ☐ asymmetric

Head control: ☐ adequate ☐ poor ☐ excessive head/neck hyper extension ☐ receives external positioning ☐ receives manual positioning ☐ reflexive position patterns

Facial: ☐ asymmetrical ☐ contortions ☐ jaw extension ☐ grimaces/tics ☐ open mouth posture ☐ increase tone ☐ decrease tone

Breathing patterns: ☐ mouth breather ☐ audible inhalation

OBSERVATION OF FEEDING

Food consistencies: ☐ pureed ☐ ground ☐ mashed ☐ chopped ☐ bite size ☐ mixed (indicate consistencies of mixtures)

Food presented during evaluation: _____

_____

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	Indicate food Consistency	Indicate observed behaviors	Additional observations
Accepts food			
Lips			
• poor lip closure			
• drooling			
• reduced lip action to clear material			
Tongue			
• poor bolus formation/movement			
• decrease anterior/posterior movement			
• food residue			
Absence of rotary jaw movement			
Munching jaw movement			
Delayed swallow initiation			
Swallow delay			
Cough following swallow			
• Increased clearing throat			
Residual food in oral cavity			
Cued swallow			
Fatigues easily			

OBSERVATION OF DRINKING

Liquid consistencies: □ unthickened □ nectar □ honey □ pudding

Liquid presented during evaluation:_____

_____

	Indicate Liquid consistency	Indicate observed behaviors	Additional observations
Tongue thrust			
Reduced tongue retraction			
Anterior loss			
Limited jaw opening			
Limited upper lip closure over cup			
Delayed swallow			
Coughing following drink			

ADDITIONAL COMMENTS

_____

_____

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RECOMMENDATIONS

1. _____

2. _____

3. _____

4. _____

INTERDISCIPLINARY CONSULTATION CONDUCTED BY

_____
Speech/language pathologist

_____
Occupational therapist

_____
Nurse

ADDITIONAL PARTICIPANTS

Signature:	Title:
_____	_____
_____	_____
_____	_____

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SWALLOWING AND FEEDING PLAN

Date of plan: _____
Review date: _____
Student: _____ Date of birth: _____
School: _____ Teacher: _____
Dysphagia Case Manager: _____
If there are any questions regarding this student's feeding plan, please contact the Case Manager at the following location(s) _____ Phone #s: _____
Case history: _____

FEEDING RECOMMENDATIONS

Positioning: _____
Equipment: _____
Tube Fed: ☐ tube fed/nothing by mouth ☐ tube and oral fed
amount fed orally: _____

Diet/food prep

Food consistency: ☐ pureed ☐ ground ☐ chopped ☐ mashed ☐ bite sized
Liquid consistency: ☐ no liquids ☐ thin liquids
☐ thickened liquids (circle): nectar honey pudding
Other: _____

FEEDING PLAN TECHNIQUES/PRECAUTIONS

Amount of food per bite: _____
Food placement: _____
☐ Keep student in upright position _____ minutes after meal
☐ Offer a drink after _____ bites
Additional precautions/comments: _____

SWALLOWING AND FEEDING PLAN IN SERVICE TRAINING

I, the undersigned, have read and been trained on implementing the swallowing and feeding plan for _____ _____, I agree to follow the swallowing program as specified.

Name	Position	Date Review	Date

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PRE VFSS INFORMATION FORM

Date form completed:_____

Name:_____ Date of birth:_____

Diagnosis:_____CA_____

Referring SLP:_____

Brief medical history_____

_____

_____

Positional concerns/adaptive equipment currently used at school:_____

_____

_____

Current diet:_____

_____

SUMMARY OF INTERDISCIPLINARY CONSULTATION

The following was observed during a clinical observation of the student's feeding and swallowing at school.

Oral phase

- ☐ drooling
- ☐ pocketing: ☐ lateral sulcus ☐ anterior sulcus
- ☐ not clearing the oral cavity before swallow
- ☐ anterior loss/poor lip seal
- ☐ excessive chewing
- ☐ hyper/hypo sensitivity
- ☐ difficulty with bolus formation

Pharyngeal phase inferences

- ☐ coughing/choking: _____ before _____ after _____ during swallow
- ☐ delay in triggering swallow
- ☐ wet/gurgly voice quality after swallow
- ☐ decreased/absent laryngeal elevation
- ☐ expectorating food
- ☐ repetitive swallows

Information that the school system would like to get from the VFSS is as follows:

1. _____
2. _____
3. _____
4. _____

We have included a Tammany Parish School Board Authorization for Release of Confidential Information

SWALLOWING AND FEEDING TEAM PROCEDURE CHECKLIST

Student:_____ School:_____
SLP:_____OT:_____ Nurse:_____

PROCEDURE	**DATE**
Referral form completed and sent to Dysphagia Coordinator	_____
Parent/Guardian informed of consent	_____
Interdisciplinary consultation conducted	_____

IEP meeting held (check attendance)

1. Person attending:
   - ☐ teacher ☐ IEP facilitator ☐ administrator
   - ☐ SLP ☐ nurse ☐ other:_____
   - ☐ OT ☐ parent/guardian
2. Addressed at IEP (check issues addressed)
   - ☐ emergency plan ☐ referral to physician ☐ special diet
   - ☐ medical history ☐ release of information ☐ temporary feeding plan

Training is conducted (check and date) _____
_____ emergency plan _____feeding plan

Medical information/referral from physician is requested (check and date) _____
_____ clinical evaluation _____ VFSS

Studies conducted (VFSS attended by case manager) _____

Diet prescription is sent to/received from physician _____

Diet order faxed to food service supervisor _____

School cafeteria manager and parent/guardian notified of diet order _____

Diet changes started at school _____

Therapy feeding guidelines and swallowing treatment plan developed _____

IEP reconvened to update information _____

School personnel and parent/guardians trained in feeding/treatment plan _____

Feeding/treatment plan initiated _____

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