SPEECH THERAPY
SWALLOWING EVALUATION

Name:	Unit/Room:	DOB:
Medical Dx:		Onset Date:
Treatment Dx:		MD Order Date:

Reason for Evaluation:

Past Medical Hx/Diagnosis:

Prior Therapy: (recent)

Present Diet Texture:

Current Method of Nutrition (circle) Oral NG Tube G Tube NPO

Prior Level of Function: (pre problem)

Resident Goals:

SUBJECTIVE:

OBJECTIVE / CURRENT LEVEL OF FUNCTION / TESTS AND MEASURES:

Orientation: (circle) Person Place Time	Communication: (circle) Verbal Non-verbal None	Speech Intelligibility:
Follows Directions: (circle) 1 Step 2+ Step Inconsistent Unable		
Comprehension:	Level of Responsiveness:	Other:
Hx Aspiration:	Respiratory Status:	

ORAL EXAMINATION:

Lips	Tongue:
Cheeks	
Velar Function	Dentition: ___ Normal ___ Missing Teeth ___ Edentulous
Volitional Swallow	Condition: ___ Good ___ Adequate ___ Poor
Volitional Cough	Dentures: ___ Owns / Present ___ Owns /Not Present ___ Does Not Own
Phonation/Vocal Quality	Type: ___ Full Upper ___ Partial Upper
Oral Awareness	___ Full Lower ___ Partial Lower
Other:	

ORAL PHASE

thin	nectar	honey	pudding	regular	mech soft	puree	FINDINGS
							food, liquid leaks from mouth
							separation of food in mouth
							loss of bolus control
							food falls into lateral sulcus
							food remains on tongue or hard palate
							slow oral transit
							reduced, prolonged or absent rotary chewing
							excessive nonproductive chewing w/no swallow

At Risk for : (circle) Penetration Aspiration

PHARYNGEAL PHASE

thin	nectar	honey	pudding	regular	mech soft	puree	FINDINGS
							poor elev of hyoid/thyoid cartilage
							repeated swallows per bolus
							complaints of throat discomfort
							expectoration after swallow
							coughing pre swallow
							coughing during swallow
							cough post swallow/throat clearing
							gurgly voice post swallow
							excessive secretions
							nasal regurgitation

Speech Language Pathologist

Date

NAME: DOB:

ASSESSMENT

GOALS

SHORT TERM _____ WEEKS

1 Res/family/caregiver will understand and follow through feeding strategies % of the time.

2 Res will perform oral motor exercises with % accuracy.

3 Res will use introduced compensatory strategies % of the time when eating / drinking.

4 Res will tolerate therapeutic feed trials for diet upgrade with safe airway protection % of the time.

5 Other:

6 Other:

LONG TERM _____WEEKS

1 Res will tolerate current diet recommendations without any overt signs/sx of aspiration or laryngeal penetration % of the time.

2 Res will improve strength / ROM of oropharyngeal musculature to tolerate upgrades in liquid / solid consistencies, without overt signs/ symptoms of aspiration or laryngeal penetration 100% of the time.

3 Res will tolerate diet upgrade of _____ with _____liquids without any overt signs/symptoms of aspiration or laryngeal penetration 100% of the time.

4 Res/family/caregiver will understand and follow through feeding strategies 100 % of the time.

5 Other:

6 Other:

SPEECH THERAPY PLAN OF CARE

- ☐ Oral Motor Exercises
- ☐ Lingual Bowling / Icing
- ☐ Thermal Stimulation
- ☐ Therapeutic Feeding
- ☐ Swallowing Strategy Instruction
- ☐ Pharyngeal Exs
- ☐ O.M. Stim
- ☐ Clinical Analysis of Diet Modification
- ☐ Caregiver Training and/or Resident/Family Education
- ☐ Other _____
- ☐ Other _____
- ☐ Other:

☐ Speech Therapy Not Indicated at This Time

Type: Skilled Speech Therapy (PPS)
Frequency: Minimum of _____ days/week
Target of _____ minutes per week
Duration: _____ weeks 4 wk max
Cert Period: _____ to _____ 30 day max

OR

Type: Skilled Speech Therapy (Non- PPS)
Frequency: _____x per week
OR _____# of visits
Duration: _____ weeks
Cert Period: _____ to _____

_____ _____
Speech Language Pathologist **Date**

I certify the need for these services furnished under this plan of care for the above cert period.

Physician Signature / Date