Swallowing and Feeding Team Procedure Checklist

Student Name: _____ **Teacher:** _____

SLP: _____ **OT:** _____

Referring School: _____

Initial & Date by Verifying Staff Member	Description of Documentation	Review Team Check Off
	1. IEP Team meeting held (✓ team members in attendance): ❑ Parent/guardian ❑ Teacher ❑ IEP Facilitator ❑ Administrator ❑ SLP ❑ Nurse ❑ OT ❑ Other _____ ❑ Other _____	
	2. Issues Addressed at IEP (✓ issues addressed): ❑ Emergency Plan ❑ Release of Information ❑ Medical History ❑ Temporary Feeding Plan ❑ Referral to Physician ❑ Special Diet	
	3. Review of cumulative file for any information pertinent to feeding.	
	4. Review of medical records for any information pertinent to feeding (clinical evaluation or VFSS).	
	5. Copies of completed referral form, completed parent input form, and signed release of records sent to District Office, ESE Dept., Attn: Speech/Language Program Coordinator.	
	6. Feeding observation/evaluation conducted, if needed.	
	7. Feeding plan developed based on record review, parent input and feeding observation/evaluation.	
	8. IEP Team reconvened to update information.	
	9. School staff/parent training provided if necessary to implement feeding plan.	
	10. Feeding plan (Form F) dispersed to appropriate school staff (teacher, school nurse, SLP) and parent.	

Return Referral (Form B), Parent Input (Form C), and Release of Records/Consent (Form D) to:
District Office ESE Dept., Attn: Sp/Lang Program Coordinator, phone x42626, fax x42117

Feeding/Swallowing Team Referral Form

Date form completed: _____

Student: _____ DOB: _____ School: _____

Student ID#: _____ Medicaid #: _____ Teacher: _____

SLP: _____ Contact Person? ❑ OT: _____ Contact Person? ❑

Nurse: _____ Contact Person? ❑ Contact phone #: _____

Parent/Legal Guardian: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

What language is spoken at home? ❑ English ❑ Spanish ❑ Other: _____

ESE Program(s): (Check all that apply)

❑ Lang. Impaired	❑ SLD	❑ OT	❑ PT
❑ Sp. Impaired	❑ EBD	❑ TBI	❑ DD
❑ ID (supported)	❑ VI	❑ DHH	❑ EMH
❑ ID (participatory)	❑ ASD	❑ OHI/OI	

Educational Placement: _____ Grade: _____

Medical Diagnosis (List all): _____

_____

Current medications: _____

_____

Allergies: _____

_____

Has a Video Swallow study been performed? ❑ yes ❑ no (Attach if available.)

What is the student currently being fed at school? ❑ School prepared meals
❑ Parent prepared meals

If school food, it is altered in any manner? ❑ N/A If yes, how? _____

_____

Food Consistencies ❑ Bite size/regular ❑ Chopped ❑ Mashed ❑ Ground ❑ Pureed
❑ Mixed (indicate consistencies of mixtures)

Liquid Consistencies ❑ Un-thickened/regular (thin) ❑ Nectar ❑ Honey ❑ Pudding

How is student currently being fed? ❑ Oral self-feeding ❑ Oral fed by others ❑ Tube fed

Equipment currently used to aid in feeding: _____

_____

Are there current doctors orders related to diet or feeding? ❑ yes ❑ no (If yes, attach.)

Check all that apply:

Medical History/Information

❑ History of chronic pulmonary difficulties

- ❑ Past diagnosis of aspiration, pneumonia, or reflux
- ❑ Receives nutrition through tube feeding
- ❑ Vocal fold paralysis
- ❑ Cleft palate
- ❑ Reported medical history of swallowing problems
- ❑ History of head injury
- ❑ Less than normal weight gain or growth/failure to thrive
- ❑ Frequent constipation, diarrhea, or other gastrointestinal tract problems
- ❑ Structural abnormalities, e.g. cleft palate

Observed Behaviors

- ❑ Requires special diet or diet modifications (e.g., baby foods, thickener, soft food only)
- ❑ Poor upper body control
- ❑ Poor oral motor functioning
- ❑ Maintains open mouth posture
- ❑ Excessive drooling
- ❑ Nasal regurgitation
- ❑ Food or liquid remains in mouth after meals (pocketing or pooling)
- ❑ Wet breath sounds and/or gurgling voice quality following meals or drinking
- ❑ Coughs, chokes, vomits, or gags during or after meals
- ❑ Swallowing solid food without chewing
- ❑ Effortful swallowing
- ❑ Eyes watering/tearing and/or runny nose during mealtime
- ❑ Unusual head/heck posturing during eating
- ❑ Hypersensitive gag reflex
- ❑ Chronic refusal to eat
- ❑ Food and/or drink escaping from the mouth or trach tube
- ❑ Slurred speech
- ❑ Prolonged feeding time, e.g. mealtime takes more than 30 minutes
- ❑ Choking episodes
- ❑ Difficulty initiating a swallow (excessive chewing)
- ❑ Throat clearing
- ❑ Temperature spikes
- ❑ Bradycardia (slow heart rate) as determined by nurse
- ❑ Difficulty coordinating breathing and eating or drinking
- ❑ Audible swallows and/or frequent reflux (belching)

Other pertinent information regarding feeding/eating: _____

_____

_____

_____

_____

Note: If parent has not returned forms and team believes there is a critical need, send in referral form alone.

PARENT/GUARDIAN INPUT – SWALLOWING AND FEEDING

Student Name: _____ Date of Birth: _____

Current Height and Weight: _____ Physician: _____

Allergies: _____

Does your child feed himself/herself? ❑ Yes, independently ❑ Yes, with assistance ❑ No
Does your child enjoy mealtime? _____
How do you know when your child is hungry? _____
How do you know when your child is full? _____
How long does it take your child to complete a meal?
❑ <10 minutes ❑ 10-20 minutes ❑ 20-30 minutes ❑ 30-40 minutes ❑ 40+ minutes
Who usually feeds your child? _____
Who else can feed your child? _____
Does your child have any food allergies? _____
What is the average amount of food and liquid your child eats/drinks during a meal? _____
_____

Does your child have difficulty with any of the following?

❑ Chewing	❑ Gurgling or "wet" voice	❑ Choking during a meal
❑ Breathing	❑ Chronic ear infections	❑ Biting on utensils
❑ Vomiting	❑ Drooling:	❑ Coughing with or without spraying of food
❑ Gagging	❑ Constant	❑ Being touched around the mouth
❑ Noisy breathing	❑ Frequent	❑ Chronic respiratory problems (pneumonia)
❑ Tongue thrust	❑ Occasional	❑ Very fussy eating behaviors

Was or is your child being fed through a feeding tube? ❑ Yes ❑ No
If yes, when? _____
_____

Why?
❑ Aspiration ❑ Medication ❑ Transition to oral feeding ❑ Liquids only ❑ Other_____
_____

What are your child's food preferences?

Likes	Dislikes
_____	_____
_____	_____
_____	_____

What kinds of food does your child eat?
Liquids: ❑ Regular/thin ❑ Thickened
Solids: ❑ Bite size pieces ❑ Chopped ❑ Ground ❑ Mashed ❑ Pureed
❑ Table foods (what other family members are eating)

Does your child take any nutritional supplements? ❑ Yes ❑ No
If yes, please specify _____

_____

Do certain foods/liquids appear to be more difficult for your child to eat? _____

_____

_____

How is your child positioned during feeding?
❑ Sitting in a chair ❑ Sitting in a wheelchair ❑ Sitting ❑ Held on a lap
❑ Reclined ❑ Lying down ❑ Other _____

What utensils are used?
❑ Bottle ❑ Spoon ❑ Fork ❑ Sippy cup ❑ Cup (no lid) ❑ Straw
❑ Other adaptive equipment _____

Has your child ever had a swallow study? ❑ Yes ❑ No If yes, when? _____
What were the results: _____

_____

_____

Additional Comments or Concerns _____

_____

_____

_____

_____

Parent/Guardian Signature _____ Date _____

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Heather Fiorentino, Superintendent

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Parent/Guardian Permission

I understand and agree that my child will receive the services of the Swallowing & Feeding Team. Services may include any or all of the following: consultation with IEP Team members, training for IEP Team members (including the student, if appropriate), provision of resources and/or an assessment.

Parent/Guardian Signature _____ Date _____

INTERDISCIPLINARY CONSULTATION SWALLOWING AND FEEDING OBSERVATION/EVALUATION

Date of evaluation: _____

Student: _____ Student ID #: _____ Age: _____
DOB: _____ School: _____ Exceptionality: _____
Classroom Teacher: _____ Diagnosis: _____ Physician: _____
SLP: _____ OT: _____ Nurse: _____
Medical History: _____
_____
_____

GENERAL INFORMATION

During this consultation the student was:
Seating ❑ Wheelchair ❑ Tumble form ❑ Rifton Chair ❑ Other _____
Student Position ❑ Upright ❑ Semi upright ❑ Reclining <30° ❑ Other _____
Food Presented by ❑ Classroom teacher ❑ IA ❑ Parent/guardian ❑ Other _____
Utensils used ❑ Bottle ❑ Sippy cup ❑ Cup ❑ Spoon ❑ Fork ❑ Straw ❑ Other _____

GENERAL OBSERVATIONS

Behavior ❑ Cooperative ❑ Resistant ❑ Refusal ❑ Other _____
Alertness ❑ Alert ❑ Lethargic ❑ Irritable ❑ Other _____
Follows directions ❑ Verbal ❑ Gestural ❑ None ❑ Single step only
Vision ❑ No impairment ❑ Mild impairment ❑ Moderate impairment ❑ Severe impairment

GENERAL PHYSICAL OBSERVATIONS

Abnormal reflexes observed: _____
Trunk ❑ WNL ❑ Excessive extension ❑ Dystonia ❑ Scoliosis ❑ Kyphosis ❑ Asymetric
Head Control ❑ Adequate ❑ Poor ❑ Excessive head/neck hyperextension
❑ Receives external positioning ❑ Receives manual positioning
❑ Reflexive position patterns
Facial ❑ Asymmetric ❑ Contortions ❑ Jaw extension ❑ Open mouth posture
❑ Grimaces/tics ❑ Increase tone ❑ Decrease tone
Breathing Patterns ❑ Nasal congestion ❑ Mouth breather ❑ Audible inhalation

Present Signs of Risk:

❑ Choking	❑ Gagging	❑ Weight loss
❑ Reduced nutrition	❑ Reduced hydration	❑ Throat clearing
❑ Failure to thrive	❑ Pneumonia history	❑ Temperature spikes
❑ Chest pain	❑ Changes in eating habits	❑ Watery eyes
❑ Drooling	❑ Coughing	❑ Pocketing food

OBSERVATION OF FEEDING

Food Consistencies ❑ Pureed ❑ Ground ❑ Mashed ❑ Chopped ❑ Bite size
❑ Mixed (indicate consistencies of mixtures)

Food presented during evaluation: _____
_____
_____
_____
_____

	Indicate Food Consistency	Indicate Observed Behaviors	Additional Observations
Absence of rotary jaw movement			
Munching jaw movement			
Delayed swallowing initiation			
Swallow delay			
Cough following swallow			
• Increased clearing throat			
Residual food in oral cavity			
Cued swallow			
Fatigues easily			

OBSERVATION OF DRINKING

Liquid Consistencies ❑ Un-thickened ❑ Nectar ❑ Honey ❑ Pudding

Liquid presented during the evaluation: _____

	Indicate Food Consistency	Indicate Observed Behaviors	Additional Observations
Tongue thrust			
Reduced tongue retraction			
Anterior loss			
Limited jaw opening			
Limited upper lip closure over cup			
Delayed swallow			
Couching following drink			
Wet vocal quality			

SUMMARY: _____

_____

_____

RECOMMENDATIONS

❑ **Individual Swallowing and Feeding Plan**

❑ **Parent to provide Swallowing Evaluation to student's primary Physician**

❑ **Other:** _____

_____

INTERDISCIPLINARY CONSULTATION CONDUCTED BY:

_____ _____

Speech/Language Pathologist Occupational Therapist

_____ _____

Nurse Physical Therapist

ADDITIONAL PARTICIPANTS

Signature: Title:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SWALLOWING AND FEEDING RECOMMENDATIONS

Student: _____ Date of Evaluation: _____

Date of Birth: _____ Review Date: _____

School: _____ Teacher: _____

In order to provide a positive, effective and safe eating environment:

Therapeutic position for feeding:

- ❑ Symmetry
- ❑ Trunk aligned and well-supported, arms forward
- ❑ Hips, knees, ankles at 90° with neutral pelvis
- ❑ Head in neutral alignment or slight chin tuck
- ❑ Arms and elbows supported on a tray

Equipment

❑ Scoop bowl/plate	❑ Large handled spoon	❑ Universal cuff
❑ Plate guard	❑ Maroon spoon	❑ Other _____
❑ Nosey/flexy cut cup	❑ Teflon coated spoon	❑ Other _____
❑ Bent handle spoon	❑ Plexiglass straw	❑ Other _____

Feeding Guidelines:

❑ Parent prepared meals ❑ School prepared meals

Solids: ❑ Regular ❑ Chopped ❑ Soft ❑ Pureed

Liquids: ❑ Thin ❑ Nectar ❑ Honey ❑ Pudding

- ❑ Utilize pre-feeding iceing techniques
- ❑ Cut all food into bite size pieces
- ❑ Encourage alternation of solid and liquids
- ❑ Encourage alternation of sweet and bland foods
- ❑ Provide rest periods
- ❑ Student to remain seated for at least 30 minutes post eating
- ❑ Foods to avoid: _____
- ❑ Other: _____
- ❑ Other: _____
- ❑ Report any symptoms of aspiration to school nurse

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 Reviewed

SWALLOWING AND FEEDING PLAN

Student name:_____ **Date of evaluation:** _____

Teacher: _____

This plan is for use with the child named below *exclusively* and is based on his/her personal medical records and individual needs. *Not for use with other students.*

School personnel are responsible for carrying out the following recommendations.

Parent Provided Diet	Meal(s): Time of meal: Expected length of feeding:		
Universal Precautions	❑ Gloves ❑ Other		
Adults Present	Primary feeder: Others:		
Positioning	❑ Chest harness ❑ Adjust wheelchair	❑ Neck pillow ❑ Foot straps	❑ Other
Equipment Used	❑ Cut-out cup ❑ Maroon spoon ❑ NUK brush	❑ Measuring cup ❑ Regular spoon	❑ Other
Oral Alerting	❑ Cheek stretches ❑ Icing	❑ Lip stretches	
Cues Required	❑ Put lips together ❑ Swallow ❑ Look at me	❑ Get ready ❑ Open your teeth/mouth ❑ Head up	❑ Other
ques	❑ Chin support ❑ Cup to remain on lip ❑ Alternate warm and cold ❑ Music/sing to relax ❑ Rest periods ❑ Alternate sweet/bland ❑ Alternate liquid with every 2-3 bites of solid/puree	❑ Pressure to tongue base ❑ Wait for child to initiate to tip liquid ❑ Downward pressure with spoon ❑ Empty spoon ❑ Stretch legs ❑ 1/3 to ½ spoonful of solid/puree only	❑ Other
Intake – Other	❑ Remain seated 30 minutes post eating	❑ Foods to avoid:	❑ Other
	Report to Nurse Immediately ❑ Gurgly breath sounds ❑ Excessive sweating ❑ Red face ❑ Watery eyes ❑ Increase temperature ❑ Increased congestion ❑ Excessive cough/gag		
Additional Observations			

Pre VFSS Information Form

Date completed: _____

Background Information:

Name: _____ Date of Birth: _____

Diagnosis: _____ C.A.: _____

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 ❑ in the lateral sulcus ❑ in the 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/gurgling voice quality after swallow
- ❑ Decreased/absent laryngeal elevation
- ❑ Expectorating food
- ❑ Repetitive swallows

Information school system would like to receive from the VFSS:

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