Nursing In Take and Parent Interview-Safe Eating Evaluation Referral

Student's Name_____Date of Birth_____ Parents_____ District_____

Address_____ Phone_____ Phone_____

Reason for referral_____ Referred by:_____

Diagnosis (ES)/Health Concerns:_____

_____

Significant Birth History:_____

_____

_____

Other Health Conditions (Clarify onset, symptoms, current and emergency management.)

[ ] 1.Allergies [ ] pollens [ ] food [ ] medication [ ] latex [ ] specify_____

[ ] 2. Bleeding disorder [ ] 5.Diabetes [ ] 8. Learning disability [ ] 11. Hepatitis [ ] 14. Speech problem

[ ] 3. Cancer [ ] 6. Kidney disease [ ] 9. Headaches/H. injury [ ] 12. Respiratory [ ] 15. Vision problem

[ ] 4. Dental [ ] 7. Heart disease [ ] 10. Hearing problem [ ] 13. Seizures [ ] 16. Other _____

Height_____ Weight_____

West Linn Wilsonville School District/Student Services/Student Health Services
22210 SW Stafford Road, Tualatin, OR 97062 503-673-7000 or fax 503-673-7003

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Medical Care:

Physicians:_____

Date of last MD. Exam:_____

Release of Information [ ] Yes [ ] No

Recent Illnesses/Hospitalizations:_____

Medications:

NAME DAILY (D), PRN (P)	DOSE, ROUTE, SPECIAL INSTRUCTIONS	TIME

Oral Sensitivity: [ ]

Describe:_____

_____

Dental Care:

Dentist:_____ Date of Last Exam:_____ Routine Visits [ ] Yes [ ] No

Daily Routine:_____

_____

Surgeries (Clarify date, surgeon, purpose)

[ ] 1. Gastrostomy [ ] 2. Ilestomy/Colostomy [ ] 3. Pacemaker [ ] 4. Shunt [ ] 5. Tracheostomy

[ ] 6. Fundal Plication/Nissen Fundoplication [ ] 7. Other_____

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_____

Adaptive Equipment (Clarify type, directions for use)

[ ] 1. Brace/headgear [ ] 2. Catheter [ ] 3. Clothing [ ] 4. Colostomy [ ] 5. Corrective lenses [ ] 6. Eating utensils

[ ] 7. G. tube [ ] 8. Heating aid [ ] 9. Ilestomy/Colostomy bag [ ] 10. Oxygen [ ] 11. Language board

[ ] 12. prosthesis [ ] 13. Suction machine [ ] 14. Trach tube [ ] 15. Wheelchair

[ ] 16. Other

_____

_____

Feeding Evaluations:

[ ] No [ ] Yes if yes, locations_____ Date_____

Results:_____

Release of information [ ] No [ ] Yes

Barium Swallow [ ] No [ ] Yes Parent has copies of study [ ] No [ ] Yes

Results:_____

Precautions: (Not already addresses) _____

_____

Communication Patterns: [ ] 1. Non-Verbal [ ] 2. Short Phrases (List specifics below) [ ] 3. Signs

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Special approach for communication/interaction:

Dietary/GI:

[ ] 1. Poor appetite [ ] 2. Difficulty swallowing [ ] 3. Chocking [ ] 4. Absent gag reflex [ ] 5. Difficult chewing

[ ] 6. Eats small frequent meals: Times_____ [ ] 7. # Meals/ day __ [ ] 8. # Snacks/ day [ ] 9. Length of feeding time;____

[ ] 10. Food Supplement._____ [ ] 11. Refuses to eat new food textures. [ ] 12. Failure to gain weight or poor weight gain

[ ] 13. Reflux/vomiting and or spitting up during/after meals [ ] 14. Fussy after meals [ ] 15. Chronic constipation

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 feeding:_____ **After feeding**:_____

Adaptations: [ ] Uses cup (specify type_____) [ ] Uses fork [ ] Uses knife [ ] Uses spoon (amount per spoonful_____)

[ ] Drinks from straw [ ] Squirt bottle [ ] Bottle [ ] Special chair and table

Breast or bottle fed as infant_____ how long_____

Food prefrences:_____

Foods to avoid:_____

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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 asthma, aspiration, pneumonia, bronchitis, frequent or chronic respiratory infections, if yes-how often?_____

[ ] History of persistent colds/allergies, ear infections, if yes-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:_____

_____

Activity Sensitivity Tolerance:

[ ]1. Requires extra rest [ ] 2. Restricted activities;_____ [ ] 3. Tires easily [ ] 4. Does not like to lay flat on back

[ ] 5. Increased sensitivity to sensory input [ ] 6. Frequent irritability

_____

_____

_____

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Sleep Patterns: Bed time_____ Awakens at _____

[ ] Poor sleeping habits (ie difficulty going to sleep-awakens often); [ ] Wakes up sleeping [ ] Restless sleeper

_____

_____

Mobility:

[ ] 1. limited ROM movement patterns [ ] 2. Paralysis [ ] 4. Needs special transfer technique [ ] 5. Position restriction/ dislikes

_____

_____

Self-Feeding Skills:

[ ] Feeds self

[ ] Uses [ ] Spoon [ ] Fork [ ] Cup [ ] Bottle [ ] Straw

[ ] Needs frequent cues: [ ] Mouth too full [ ] Stay on task [ ] Bite size [ ] Portion control

[ ] Needs assistance with set up [ ] Opening containers [ ] Cutting food

_____

_____

Behavioral Observations While Feeding/Drinking:

[ ] Coughing, gagging choking [ ] Heimlich or intervention required [ ] Drooling [ ] Gurgling during & following swallow

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[ ] Arches back into hyperextension during/ after feeding [ ] Tires easily, need small frequent feedings

[ ] Turns head to left during and after feeding [ ] Loses liquid/ food from mouth [ ] Multiple swallows [ ] Poor food lateralization

[ ] Difficulty coordinating breathing/swallowing [ ] Emesis

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Physician Concerns:

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Parental Concerns:

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RN Signature_____ Date_____

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