SWALLOWING DISORDERS FOLLOW-UP ASSESSMENT
Instructions for Completion

If any response to any statement (1-17) on the **Swallowing Disorders Checklist** (**Checklist**) is "YES", the **Swallowing Disorders Follow-Up Assessment** (**Assessment**) must be completed (unless the provider or DDSN Regional Center has a therapist who can evaluate the Checklist and the therapist conducts an assessment and documents the results of the assessment or unless otherwise noted on previous Consultation Summary). The completed **Assessment**, along with the **Checklist** and supporting documentation, must be submitted to DDSN or the provider's OT/SP within ten (10) business days of completion of the **Checklist**, five (5) business days for a choking incident. These should be submitted even if the relevant medical information is not available at that time.

The **Assessment** is designed to provide medical information that will assist in determining if the person could potentially be at risk for complications related to dysphagia, aspiration and/or GERD. It is recommended that the **Assessment** be completed by a trained medical professional (e.g., nurse). If a trained medical professional is not accessible, a non-medical professional or paraprofessional may complete the **Assessment**.

The **Assessment** must be completed using the person's current and historical medical and residential documentation. This may include, but is not limited to: current medication list, physician's orders, medical assessments, evaluations, diagnostic testing, residential assessments as well as any available historical information. The **Assessment** is not considered to be "complete" unless a response to all items is documented, or marked "not applicable" (N/A), and all required medical records are included. If medical records are not readily available, documentation of the efforts made to obtain the records must be provided. All outstanding documentation should be submitted to DDSN or the providers OT/SP within ten (10) business days of submission of the **Checklist/Assessment**. Note if documentation is unobtainable.

If this person has been recently admitted to a DDSN Regional Center or provider, the available medical records may not contain sufficient information for adequate completion of the **Assessment**. In these situations, family members and/or previous residential service providers should be contacted in an effort to obtain the information. This may include securing the names of physicians, therapists or medical facilities where evaluations, examinations, or treatments may have been provided so that a signed release of information can be forwarded with a request for the person's records.

To complete, identify the person by **FIRST AND LAST NAME** with **MIDDLE INITIAL**. Include name of **RESIDENCE/PROVIDER** and **DATE OF BIRTH**.

- DIAGNOSES: Is the person diagnosed with or have a history of any of the listed diagnoses? Check boxes for all confirmed diagnoses for the person. Note "?" if the diagnosis is questionable and "Hx" if there is a past history of a specific diagnosis. List any "other" pertinent diagnoses which may include: COPD, recurrent gastritis, history of GI bleed, etc. Check "None" if the person has none of the listed diagnoses.

- MEDICATIONS: Does the individual take any of the medications listed? Check boxes for any of the medications listed that the person receives. Provide the dosage that is ordered and the administration time(s) for each medication. If Miralax is ordered, note if this medication is ("Yes") or is not ("No") being thickened, the dosage given and time given. List any PRN medications (taken on an as needed basis) that are given for gastrointestinal (GI) or respiratory symptoms (e.g., Tums, over the counter cold/cough medications, inhalers, etc.) and the frequency they are used. "Comments" may be used for additional medications as needed. Check "None" if the person receives none of these medications.

- MEDICATIONS ADMINISTERED: Check the appropriate box noting if the person's medications are provided whole (with liquid/mixed in a puree texture), crushed and mixed in a puree texture or whether they are provided in liquid form.

- Is this person's HEAD OF BED ELEVATED? Check "Yes" or "No."

- HAVE THERE BEEN ANY PSYCHOTROPIC OR SEIZURE MEDICATION CHANGES IN THE LAST 12 MONTHS: Check "yes" or "no" as to whether there have been any changes to the person's psychotropic or seizure medications (i.e., increase or decrease in dosage) in the past 12 months. If "YES", document the changes that were ordered and the date these changes took effect.

- CURRENT DIET CONSISTENCY: Note the diet consistency that the person currently receives (e.g., regular, bite size, chopped, mechanical soft, ground, puree, etc.).

- CALORIE RESTRICTIONS: Note any calorie restrictions the person may have (e.g., 1800 calorie, 1200 calorie, No added sugar, etc.). Note "none" if no caloric restrictions are ordered.

- CURRENT LIQUID CONSISTENCY: Note the liquid consistency the person currently receives. If liquids are being thickened, note the specific consistency that is ordered (i.e., thin, nectar, honey, pudding).

- HIGH CALORIE SUPPLEMENTS: List any high calorie supplements the person receives that are being used to increase their caloric intake (e.g., Ensure, Ensure +, Boost, Boost pudding, etc.). Note HOW MANY TIMES per DAY these supplements are provided and the times they are given.

- CALORIC CHANGES IN THE PAST YEAR: Check "Yes" or "No" as to whether the person has had a physician ordered change in their caloric intake in the past 12 months (e.g., initiation of a reduced calorie diet, high calorie supplements, etc.) Note the CHANGES that were made and the DATE these changes went into effect.

- TIMES MEALS SERVED: Note what time the person's BREAKFAST, LUNCH and DINNER are served.

- INDEPENDENT/DEPENDENT EATING or PHYSICALLY ASSISTED BY STAFF FOR EATING: Note whether the person is able to independently feed themselves once set up at the table. If not, note whether they are dependently fed by staff or whether staff

provide any type of physical assistance (e.g. hand over hand assistance during the meal or for part of the meal, assistance for liquids, assistance for scooping food, etc.) during the meal.

- SUPERVISION LEVEL DURING MEALS: Note specifically how the person is supervised during meals (e.g., 1:1 supervision, staff at the table during meals, staff in the dining room during meals, staff makes visual contact periodically during meals, etc.).

- ADAPTIVE DINING EQUIPMENT: List all adaptive dining or positioning equipment the person uses during meals (i.e., adaptive spoon, adaptive plate, adaptive cup, wheelchair headrest during meals, etc.).

- TUBE FED: Check "yes" if the person is fed via a feeding tube. If "yes", note the person's current feeding orders including water bolus orders and whether the person receives bolus feedings (i.e., via syringe or gravity bag) or uses a continuous feeding pump.

- 12 MONTH WEIGHT HISTORY: Note the person's HEIGHT and IDEAL WEIGHT RANGE (IWR). Note the person's BMI if available. (This information may be available on physician notes, hospital documentation, dietary information, etc.) If this information is not available, mark n/a. Provide the person's weight for the last 12 months, including the MONTH and the YEAR the weight was obtained, beginning with the most current weight. If weights are not available for a particular month note the reason next to that specific month. (e.g., scale broken, person refused to be weighed, in hospital, etc.). If a weight is possibly inaccurate, note the reason next to that specific weight (e.g., scale discrepancy, uncooperative during weighing, etc.).

12 MONTH MEDICAL HISTORY:

- UPPER RESPIRATORY INFECTIONS: Note any upper respiratory infections the person has had in the past 12 months, providing the DATE diagnosed and the TREATMENT ordered. Check "NONE" if the person has had no known upper respiratory infections or "UNKNOWN" if medical history is not available.

- PNEUMONIA: Note any documented episodes of pneumonia the person has had in the past 12 months, providing the DATE diagnosed and the TREATMENT ordered. If the information is available (via treatment note or CXR), note whether the infiltrate was in the RIGHT or LEFT lung by checking the corresponding box. If this information is not available, do not check either. Check "NONE" if the person has had no known episodes of pneumonia or "UNKNOWN" if medical history is not available.

- CHEST X-RAYS: Note the dates of any chest x-rays (CXR) the person has had in the past 12 months and provide copies of all radiology reports that correspond with these dates. Check "NONE" if no CXRs have been performed in the last 12 months or "UNKNOWN" if medical history is not available.

- BLOODWORK: Provide the person's most recent Hemoglobin and Albumin levels, the date the bloodwork was performed and the stated normal range for the person.

- HOSPITALIZATIONS: Note any hospitalizations (including ER visits) the person has had in the past 12 months, providing **DATES OF ADMISSION/DISCHARGE**, and **DISCHARGE DIAGNOSIS**. Provide copies of admission and discharge summaries for all hospitalizations/ER visits. Also provide copies of any diagnostic testing or evaluation/treatment that was performed related to respiratory, swallowing or GI problems addressed during this hospitalization. (Do not provide copies of "Discharge Instructions for the Patient.") Check "NONE" if this person has had no hospitalizations (including ER visits) in the last 12 months or "UNKNOWN" if medical history is not available.

- DIAGNOSTIC TESTING and EVALUATIONS: **ATTACH COPIES OF ALL NOTES** and **TESTING RESULTS RELATED TO ANY TESTING/EVALUATIONS LISTED BELOW**. (If copies of documentation have been provided with a previously submitted **Swallowing Disorders Follow-up Assessment** and the testing/evaluation is referenced in the previous **Consultation Summary**, copies do not need to be re-submitted.)

NOTE: Document "N/A" if testing/evaluation has not been performed. Document "UNKNOWN" if medical history is not available.

- Modified Barium Swallow study (MBS)/date: Provide date of testing and a copy of the person's most recent MBS results if this testing has been performed. If the person has had more than one MBS in the past 12 months, provide results for all tests that were performed. Results must include a formal report from Speech Therapy. Results may include a preliminary Speech Therapy report and a report from Radiology.

- Gastroenterology (GI) Referrals/date: Provide date of visit and copies of any documentation related to GI visits that have occurred in the past 12 months. Also provide copies of any documentation addressing the reason for the GI referral.

- Esophagram/Barium Swallow (BS)/date: Provide date of testing and a copy of the person's most recent Esophagram/BS results if this testing has been performed. Results must include a procedure report from Radiology and documentation from follow-up visits with the PCP or GI to discuss the results.

- UGI series/date: Provide date of testing and a copy of the person's most recent UGI results if this testing has been performed. Results must include a procedure report from Radiology and copies of follow-up visits with the PCP or GI to discuss the results.

- Esophagogastroduodenoscopy (EGD)/date: Provide date of testing and a copy of the person's most recent EGD results if this testing has been performed. If the person has had more than one EGD in the past 12 months, provide results from all procedures that have been performed. Results must include a detailed report of the procedure (i.e., operative report) and copies of documentation from follow-up visits with the PCP or GI to discuss the results. Also, include results of biopsies that were taken during the procedure. (Do not include "Discharge Instructions for the Patient.")

- H Pylori testing: Document if the person has previously been tested for H Pylori, the date of testing and the results of the testing. Note "YES" or "NO" as to whether the person was re-tested for eradication following the initial treatment and the date and

results of re-testing if it occurred. If the person required a second treatment, note in "comment" section whether they were retested after the second treatment.

- Gastric emptying study/date: Provide date of testing and a copy of the person's gastric emptying study results if this testing has been performed. Results must include a report of the procedure and copies of follow up visits with the PCP or GI to discuss the results.
- OT Evaluation: Provide a copy of the person's most recent Occupational Therapy evaluation.
- ST Evaluation: Provide a copy of the person's most recent Speech Therapy evaluation.
- NUTRITIONAL CONSULTATIONS/REVIEW: Provide copies of the person's Nutrition (Dietary) Consultations and/or documentation from the past 12 months.
- COMMENTS: Additional information related to diagnostic testing/evaluations may be provided. Also, provide any further information that may be useful in assessing the person's current risk for problems associated with dysphagia and/or GERD.

The person completing this assessment should **SIGN** and **DATE** the form upon completion. **EMAIL ADDRESS** and **PHONE NUMBER** must also be provided for any further communication that may be needed. Include **EMAIL ADDRESS** for return of the **Consultation Summary**.

When submitting to DDSN, the **SWALLOWING DISORDERS CHECKLIST, SWALLOWING DISORDERS FOLLOW-UP ASSESSMENT** and all supporting documentation must be submitted to:

Deborah Denny Gahagen
Executive Suite
SC Department of Disabilities and Special Needs
3440 Harden Street Extension
Columbia, SC 29203
(803) 898-9656 Fax
dgahagen@ddsn.sc.gov

All documents, including Protected Health Information (PHI) which are emailed, must be sent via encrypted email or facsimile.

****A **Checklist/Assessment** that is completed due to a choking incident or any concern, (i.e., significant weight loss, ongoing acute onset of refusal to eat, sudden onset of solid food dysphagia, significant acute change in feeding/swallowing status, etc.) that is being submitted to DDSN should be submitted directly to Mika M. Walpole, Coordinator of Dysphagia Services, via fax at (843) 832-5588 or by email to: mwalpole@ddsn.sc.gov.

****Any additional documentation that is requested by DDSN for adequate review of a submitted **Checklist/Assessment** should be provided within ten (10) business days of the request or documentation (written or email) of the reason for further delay should be provided. All additional supporting documentation that is requested should be submitted directly to Mika M. Walpole, Coordinator of Dysphagia Services, via fax at (843) 832-5588 or by email to: mwalpole@ddsn.sc.gov.