SWALLOWING DISORDERS
FOLLOW-UP ASSESSMENT

THOROUGHLY REVIEW INSTRUCTIONS BEFORE COMPLETING

Name: _____ Residence/Provider: _____ DOB: _____

DIAGNOSIS: Is this person diagnosed with or have a history of any of the following?

☐Dysphagia ☐Risk for Aspiration ☐Non-cardiac Chest Pain ☐Down Syndrome ☐edentulous
☐Hiatal Hernia ☐Confirmed Aspiration ☐Frequent c/o Gastric Discomfort ☐Asthma ☐limited dentition
☐GERD ☐H Pylori ☐Decreased Esophageal Motility ☐Barrett's Esophagus
☐PICA ☐Esophageal Stricture ☐Nissen Fundoplication ☐Other: _____

MEDICATIONS: Does this person take any of these medications? ☐None

☐Reglan(metoclopramide): Dose_____ Administration time(s): _____
☐Zantac(ranitidine): Dose_____ Administration time(s): _____
☐Pepcid(famotidine): Dose_____ Administration time(s): _____
☐Dexilant (dexlansoprazole) Dose_____ Administration time(s): _____
☐Nexium(esomeprazole): Dose_____ Administration time(s): _____
☐Prevacid(lansoprazole): Dose_____ Administration time(s): _____
☐Prilosec(omeprazole): Dose_____ Administration time(s): _____
☐Protonix(pantoprazole): Dose_____ Administration time(s): _____
☐Nebulizer treatment/inhaler: Dose_____ Administration time(s): _____
☐Miralax(polyethylene glycol): Thickened? ☐Yes ☐No Dose_____ Administration time(s): _____
☐PRN medications for gastrointestinal or respiratory symptoms: Med:_____ Frequency of use: _____
Comments: _____

MEDICATIONS ADMINISTERED: ☐whole ☐crushed in puree ☐liquid **HEAD OF BED ELEVATED**? ☐Yes ☐No

Have there been any PSYCHOTROPIC or SEIZURE medication changes in the last 12 months: ☐Yes ☐No
If yes, list changes/date ordered: _____

CURRENT: DIET consistency: _____ **LIQUID consistency**: _____

Calorie restriction:_____

High calorie supplements:_____ How many times per day/times: _____

Caloric changes in the past year?: ☐Yes ☐No Date/Change _____

Times meals served: Breakfast:_____ Lunch:_____ Dinner:_____

☐eats INDEPENDENTLY or ☐DEPENDENTLY fed by staff ☐Requires physical assistance from staff during meals

Supervision level during meals: _____

Adaptive dining equipment: _____

Tube Fed: ☐Yes ☐Bolus (☐gravity ☐syringe) ☐Continuous feeding pump

Feeding orders: _____

12 MONTH WEIGHT HISTORY: (GIVE MONTH/YEAR: WEIGHT): NOTE IF INFORMATION NOT AVAILABLE

Height:_____ IWR:_____ BMI:_____

___/___:___lbs.	___/___:___lbs.	___/___:___lbs.
___/___:___lbs.	___/___:___lbs.	___/___:___lbs.
___/___:___lbs.	___/___:___lbs.	___/___:___lbs.
___/___:___lbs.	___/___:___lbs.	___/___:___lbs.

PLEASE SEE NEXT PAGE FOR ADDITIONAL REQUIRED INFORMATION

12 MONTH MEDICAL HISTORY

Upper Respiratory Infections (date/treatment): ☐None ☐Unknown

_____/_____

_____/_____

_____/_____

PNEUMONIA (date/treatment) right/left lung: ☐None ☐Unknown

_____/_____ ☐Right ☐Left

_____/_____ ☐Right ☐Left

_____/_____ ☐Right ☐Left

Chest X-RAYS: ☐None ☐Unknown (dates – attach results):_____

BLOODWORK (level): Hgb:_____(range:_____) Albumin:_____(range:_____)
Date:_____ Date:_____

HOSPITALIZATIONS (admission/discharge dates and DIAGNOSES): ☐None ☐Unknown

ATTACH ADMISSION/DISCHARGE SUMMARIES (if available)

Dates:_____ Diagnoses:_____

Dates:_____ Diagnoses:_____

Dates:_____ Diagnoses:_____

DIAGNOSTIC TESTING and EVALUATIONS ☐Unknown

ATTACH COPIES OF ALL NOTES and TESTING RESULTS FOR ANYTHING LISTED BELOW

Modified Barium Swallow study (MBS)/date:_____

Gastroenterology Referral(s)/date:_____

Esophagram/Barium Swallow/date:_____

Upper Gastrointestinal series (UGI)/date:_____

Esophagogastroduodenoscopy (EGD)/date:_____

H Pylori testing date & results:_____ Re-tested for eradication? ☐Yes ☐No Results:_____

Gastric Emptying study:_____

OT Evaluation:_____ ST Evaluation:_____

Nutritional Consultations/Review:_____

Comments:_____

Person completing assessment:_____ Date:_____

Email:_____ Phone #:_____

****MUST INCLUDE EMAIL ADDRESS FOR RETURN OF CONSULTATION SUMMARY****