CAROLINA THERAPY SERVICES

Meal/Swallowing Assessment

Patient Name: Date:

Oral Motor/Sensory Exam-

- Open Mouth; notice any abnormal anatomy
- Stick out tongue as far as you can *(lingual movement)*
- Pucker your lips *(labial movement)*
- Close your mouth; press your lips together *(labial movement)*
- Move your tongue left and right *(lingual movement)*
- Lick your lips all the way around; now go the other way *(lingual movement)*
- Stick out tongue and press against spoon; try it side to side *(lingual strength)*
- Close your mouth and try to open it when I push against it *(jaw strength)*
- Check for dentition; dentures

Labial movement:	*WFL*	*mild decreased*	*mod decreased*	*severe decreased*
Lingual movement:	*WFL*	*mild decreased*	*mod decreased*	*severe decreased*
Lingual strength:	*WFL*	*mild decreased*	*mod decreased*	*severe decreased*

Comments*:* _____

_____

Velar Symmetry-

- Open your mouth and say "ahhhh" *(velar symmetry and elevation)*

Gag Reflex-

- Open your mouth, touch uvula with tongue depressor or teaspoon *(pharyngeal sensation*

Respiratory Support-

- Show me a cough *(airway protection, respiration muscle strength)*
- Can you clear your throat? *(airway protection, expiration muscle strength)*

Dry Swallow Assessment-

- Can you take a dry swallow for me?; palpation *(laryngeal forward and elevation movement)*

Oral sensation	*WFL*	*mild decreased*	*mod decreased*	*severe decreased*
Pharyngeal sensation	*WFL*	*mild decreased*	*mod decreased*	*severe decreased*
Dry Swallow	*WFL*	*decreased*	*absent*	

Comments:_____
_____

Food/Liquid Trials-

- ½ tsp water (can you say "ahhh"?)
- 1 tsp water (how does that feel?)
- Cup sip water (can you say "ahhh"?)
- Large Cup drink of water
- Multiple cup drinks of water
- Straw sips of water

*Move to nectar thick liquids, honey thick liquids if s/sx of aspiration are observed (s/sx of coughing? Gurgly voice?)

*Try puree, mechanical soft, regular solid foods

Check for:

- Oral Control-Bolus manipulation
- Transit of the bolus (delayed?)
- Laryngeal elevation
- Pocketing/Oral holding
- Piecemeal Deglutition
- Signs or symptoms of aspiration

Comments:_____
_____
_____
_____

Patient Name: Date:

Diet at admission_____

Diet change completed at Evaluation? Circle: **YES** or **NO**

Diet Recommendations_____

Section K:

A. Loss of liquids/solids from mouth when eating or drinking.-----**Circle: YES or NO**

B. Holding food in mouth/cheeks or residual food in mouth after meals.---**Circle: YES or NO**

C. Coughing or choking during meals or when swallowing medications.---**Circle: YES or NO**

D. Complaints of difficulty or pain with swallowing.---**Circle: YES or NO**

Z. None of the above.