Speech PDPM Component Worksheet:

Resident Name: _____ Date: _____

Circle YES or NO **Acute Neurologic Diagnosis**:
If yes, what is the diagnosis: _____

Circle YES or NO **Comorbidities: (Circle all that apply and enter ICD-10 if applicable)**

1. Diagnosis related to **past/present cerebrovascular disease, disorder, or nontraumatic event**:
   - **Aphasia, Apraxia, Dysarthria, Dysphagia, Speech Language deficits**
   - ST Co-morbidity on the PDPM ICD-10 Handout?
     If Yes, what is the dx? _____
2. Current or Past History of the following:(enter date of dx next to item)

ALS	**Oral Cancer**
Aphasia	**Laryngeal Cancer**
CVA, TIA	**TBI**
Hemiplegia	**Tracheostomy/ Ventilator**

Circle YES or NO **Cognitive Impairment:**
BIMS score: _____ Is this **less than or equal to 12?**

Circle YES or NO **Mechanically Altered Diet for Eating/ Drinking:**
If Yes, what is the altered diet texture? _____
If NPO, describe assessment of PO trial, if applicable: _____

Circle Yes or No **Swallowing Disorder:**
3-ounce water test: Pass / Fail
Dentition: _____

A. Yes/No: Loss of liquids/solids from mouth when eating or drinking
- When the resident has food or liquid in his or her mouth, the food or liquid dribbles down chin or falls out of the mouth.

B. **Yes/No**: Holding food in mouth/cheeks or residual food in mouth after meals.
- Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing)
- Food left in mouth because resident failed to empty mouth completely.

C. Yes/No: Coughing or choking during meals or when swallowing medications.
- The resident may cough or gag, turn red, have more labored breathing,
- Difficulty speaking when eating, drinking, or taking medications.
- Complaints of food or medications "going down the wrong way."

D. **Yes/No:** Complaints of difficulty or pain with swallowing.
- Resident may refuse food because it is painful or difficult to swallow.

Signature: _____ Predicted Grouper: _____