Pennsylvania
Department of Human Services

Safe Swallowing Screening

This document should be used as a tool to assist the individual and their team to help determine if a further swallowing evaluation by a physician is needed. This screening can be completed by anyone who works regularly with the individual being evaluated and has comprehensive knowledge of their care. If there is any doubt as to whether the individual should be formally evaluated by a medical professional, they should be evaluated. Please keep a copy of this screening for your records.

Individual name:

Identifier (if applicable):

Person completing form:

Date of screening:

Is a formal evaluation needed?

Date of formal Physician evaluation:

Individual History:

Has the individual had choking events in the past year?

Has the individual had any instances of pneumonia in the past year?

History of respiratory problems?

Does the individual have a dysphagia diagnosis?

Does the individual have an incomplete dentation?

*If you answered **"Yes"** to any of these questions, you should ensure that individual has regular formal evaluations with a medical professional and that all staff and caregivers are regularly trained on the individuals diet plan.*

This screening is not intended to replace regular medical care. If you have concerns about an individual's ability to safely swallow, please immediately contact the individual's medical team for a formal evaluation.

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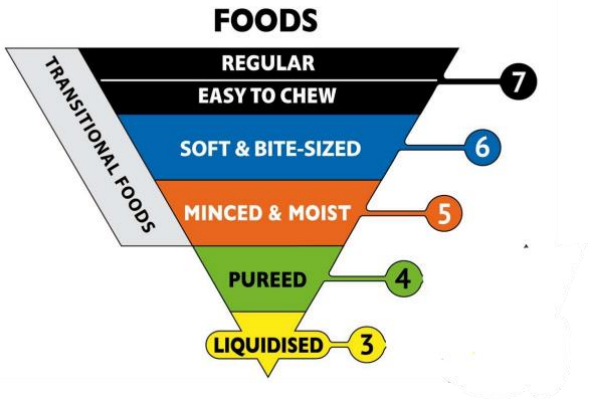
Current diet:



☐ Regular ☐ Minced and moist

☐ Easy to chew ☐ Pureed

☐ Soft and bite sized ☐ Liquidized

☐ Thin ☐ Moderately thick

☐ Slightly thick ☐ Extremely thick

☐ Mildly thick

Adaptive equipment: ☐ Bowl ☐ Cup ☐ Spoon

☐ Other:

If the individual is on a modified diet or uses adaptive equipment, ensure that staff and caretakers are regularly trained the individual's diet plan.

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Meal observation:

Please note whether the individual can complete the below items on this page free of prompting or assistance.

Able to bite food off	☐ Yes	☐ No
Keeps lips closed while chewing	☐ Yes	☐ No
Keeps food from falling out of mouth	☐ Yes	☐ No
Takes appropriately sized bites	☐ Yes	☐ No
Eats at an appropriate speed	☐ Yes	☐ No
Takes appropriate sips of liquid	☐ Yes	☐ No
Keeps liquids from falling out of mouth	☐ Yes	☐ No
Able to use tongue to remove food from cheek/teeth	☐ Yes	☐ No
Mouth is clear of debris after swallowing	☐ Yes	☐ No

*If you answered **"No"** to any of these questions, a medical professional should evaluate the individual to ensure their current diet plan is appropriate.*

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Meal observation continued:

Individual coughs while eating or drinking	☐ Yes	☐ No
Individual gags while eating or drinking	☐ Yes	☐ No
Individual chokes while eating or drinking	☐ Yes	☐ No
Individual has vocal changes while eating or drinking	☐ Yes	☐ No
Has respiration changes while eating/drinking	☐ Yes	☐ No
Individual needs multiple swallows per bite	☐ Yes	☐ No
Individual experiences pain while eating or drinking	☐ Yes	☐ No

*If you answered **"Yes"** to any of these questions, a medical professional should evaluate the individual to ensure their current diet plan is keeping them safe.*

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