

Name: _____ Date: _____

Address: _____ Assessor/Title: _____

Mission Statement: Evaluate and mitigate risk associated with physical and nutrition management.

Question:	Yes	No	Code
1. Individual chews with mouth open?			
2. Individual is dependent on someone to perform their oral care needs?			
3. Individual consumes solid foods or liquids in large volumes? (Big portions, gulping)			
4. Individual is currently taking a medical nutritional supplement?			
5. Individual's ability to bite is poor because of missing teeth or poor occlusion?			
6. Individual currently has texture or fluid modified diet?			
7. Individual vocalizes or laughs with food in mouth?			
8. Individual is unable to express themselves verbally?			
9. Individual consumes meal in 10 minutes or less?			
10. Individual is distracted when eating? (laughing, vocalizing, talking)			
11. Individual has uncoordinated movements of tongue, lips, or teeth?			
12. Individual had skin breakdown in the last year related to positioning, brace, or orthotic?			
13. Individual refuses liquids?			
14. Individual diagnosed with GERD?			
15. Individual drools or loses saliva at most or at all times?			
16. Individual receives crushed and/or liquid medication?			
17. Individual loses food from mouth while eating?			
18. Individual uses adaptive equipment during meal time and medication provision?			
19. Individual is physically dependent on staff for oral intake?			
20. Individual's neck support has decreased in the last year?			
21. Individual engages in self injurious or other abnormal behaviors around meals?			
22. Individual is unable to swallow or spit after oral intake?			
23. Individual had a weight change of plus or minus 5% in 1 month?			
24. Individual diagnosed with pneumonia two or more times in the past year?			
25. Individual ruminates?			
26. Individual fatigues during meals?			
27. Individual is unable to close their lips around a drinking glass?			
28. Individual has refused 5 or more meals within one week in the last month?			
29. Individual has pocketing or holds food in mouth?			
30. Individual's seating position does not provide adequate support when eating?			
31. Individual has visual or auditory impairment that interferes with oral intake?			
32. Individual has their bed elevated?			
33. Individual coughs numerous times during or after oral intake?			
34. Individual spits out food?			
35. Individual exhibits self-stimulation behavior during meal times?			
36. Individual has albumin less than 3.0?			
37. Individual had a choking episode in the last year?			
38. Individual has Pica?			
39. Individual pools saliva and will not swallow it?			
40. Individual gags during meals?			

Code (information from):

1	IPP
2	Medication Administration Plan
3	Current Assessment (within the last year)
4	Nursing Care Plan
5	PNM Plan
6	Other (please write in)