

The Retirement Home is responsible for completing this questionnaire for clients requiring speech language pathology due to swallowing issues.

Retirement Home _____

Name of Client _____ **Room #** _____

1. **Previous swallowing examination(s)?** Yes No

Date(s) _____

Where _____

Attached _____

2. Health History:

A	Illness/conditions (allergies, hiatus hernia, CVA, other neurological, respiratory problems, tracheotomy, diabetes, weight loss, etc.) Please note recent changes
	Medications/recent medication changes
B	Previous history of pneumonia/aspiration? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If so, how many times in last year? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> More

The client is: dehydrated malnourished experiencing weight loss

3. Diet:

A	Current Diet / Intake
	Liquids _____
	Solids _____
	Feeding Methods <input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Total Feed
	Medications/recent medication changes

B	Any diet restrictions (e.g., food allergies, etc.)
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4. Description of Symptoms:

- | | |
|--|--|
| <input type="checkbox"/> Increased fatigue at mealtimes | <input type="checkbox"/> Throat clearing: |
| <input type="checkbox"/> Breathing difficulty at mealtimes | <input type="checkbox"/> At mealtimes |
| <input type="checkbox"/> Increase secretions | <input type="checkbox"/> At times other than mealtimes |
| <input type="checkbox"/> Food/liquid falls out of mouth | <input type="checkbox"/> Coughing: |
| <input type="checkbox"/> Change in voice quality e.g., gurgled / breathy,
etc. after eating or swallowing | <input type="checkbox"/> At mealtimes |
| <input type="checkbox"/> Gagging | <input type="checkbox"/> At times other than mealtimes |
| <input type="checkbox"/> Refusal to eat | <input type="checkbox"/> Choking |
| <input type="checkbox"/> Food is left in mouth | <input type="checkbox"/> Spitting out of food |
| | <input type="checkbox"/> Reflux |
| | <input type="checkbox"/> Nasal regurgitation |
| | <input type="checkbox"/> Temperature spikes |

Has the severity of symptoms increased or decreased over time?

- Increased Decreased No Change

Decline in swallowing ability:

- Rapid Gradual Stays the same

Contact Person _____ Date _____

**Attach to Ontario Health atHome Service Referral
For new referrals fax to 519 883 5550 or Toll free 866 610 776**