

Choking Risk Screening Tool

Name:		Date of Birth:	
Agency:		Date of Review:	

↑ Risk Diagnosis

- | | |
|--|--|
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Stroke/CVA |
| <input type="checkbox"/> Closed Head Injury | <input type="checkbox"/> H/O Aspiration or pneumonia |
| <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> H/O Respiratory problems |
| <input type="checkbox"/> Hydrocephaly | <input type="checkbox"/> GERD |
| <input type="checkbox"/> _____ | |

Potential problems with chewing

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Edentulous | <input type="checkbox"/> Poor Dentition |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Does not chew |
| <input type="checkbox"/> Eats quickly | <input type="checkbox"/> Unable to feed self |

Warning Signs of Swallowing Problems

- Pocketing of food under tongue, in cheeks or roof of mouth
- Spitting food out of mouth; tongue thrusting
- Coughing before, during, or after swallowing
- Choking or H/O choking
- Regurgitation of material through nose or mouth
- Excessive drooling
- Excessive eating time
- Recurrent pneumonia (due to aspiration)

Pertinent History

- | | |
|--|---|
| <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Swallow Study _____ |
| <input type="checkbox"/> Feeding Protocol (Date:) | <input type="checkbox"/> Adaptive equipment for feeding |
| <input type="checkbox"/> Current Diet Order: | |

Comments:

Summary

- | | |
|---|---|
| <input type="checkbox"/> Needs Swallow Study | <input type="checkbox"/> Existing feeding Protocol reviewed and continued |
| <input type="checkbox"/> Needs New Feeding Protocol | <input type="checkbox"/> No intervention needed at this time (see comments) |
| <input type="checkbox"/> Feeding Protocol <input type="checkbox"/> continued, | <input type="checkbox"/> discontinued, <input type="checkbox"/> modified (Date:) |

Delegating Nurse: _____ Date: _____

Form Developed by:

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