DYSPHAGIA FACT SHEET

NAME: _____

ADDRESS: _____

STATUS: (Risk factors):

DATE DEVELOPED _____ **REVISED:**

DYSPHAGIA LEVEL _____

TOPIC:	**PROPOSED STRATEGY/ACTIVITY:**	**TRIGGERS:**
ORAL CARE AND MEDICATION ADMINISTRATION	**1.**	• Coughing with signs of struggle (watery eyes, drooling, facial redness) • Wet Vocal Quality • Vomiting • Sudden Change in Breathing • Watery eyes • Total meal refusals (X 2)-nursing notified. • Pocketing of food in mouth • Weight loss/gain of 5lbs in a month
MEAL POSITION AND ADAPTIVE EQUIPMENT	1.	
GENERAL POSITIONING AND WHEELCHAIR POSITIONING	**1.**	
NUTRITIONAL CONCERNS	1.	
SPEECH ORAL MOTOR CONCERNS	1.	
WHAT TO DO IF YOU NOTICE A DYSPHAGIA TRIGGER	1.	

SE Outreach – 8-19-05