Nutrition and Swallowing Risk Checklist

Date Completed

Note - This form is only required where a formal diagnosis relating to nutrition and swallowing is present and should accompany a formal mealtime plan and assessment.

How to use this Checklist

Assess at commencement, annually, or if a decline in functioning is noted

If there are ANY 'Yes' responses

Then complete all of these steps:

1. Raise issues with your Manager to clarify how rapidly the participant needs to seek medical attention.
2. Consult the participant's doctor, unless the issue is already being addressed.
3. Ensure a copy of the checklist is placed on the participant's file.
4. Ensure that any strategies arising from the appointment are documented and implemented as part of the Participant Support Plan.

If all of the responses are 'No'

Then complete all of these steps:

1. Ensure the participant takes a copy of this checklist to their Annual Health Review (part of the Participant Support Plan).
2. Ensure a copy of the checklist is placed on the participant's file.

1 Participant Details

Name

Date of Birth

Address

Current Weight in Kg

Current Height in cm

Body Mass Index (BMI)

To calculate the BMI, visit: http://www.mydr.com.au/tools/bmi-calculator or use this formula: Weight (Kg) ÷ Height (M)2
Example: Height = 173 cm (1.73 m) Weight = 73 Kg Calculation: 73 ÷ (1.73) x 2 = 24.41

2 Nutrition Issue Checklist

Does the Person *(If yes, please enter details into the additional comments box)*	Yes	No
1 Have a BMI **less than 19**? (This may be an indication the person is underweight and at risk of malnutrition)	☐	☐
2 Have a BMI more than 25? (This may be an indication the person is overweight and at risk of weight-related conditions)	☐	☐
3 Receive tube feeding?	☐	☐

Does the Person	Yes	No
4 Require others to assist them to eat or drink?	☐	☐
5 Have less appetite than they used to have?	☐	☐
6 Have any special diet, including:		
- Texture modified diet (e.g. pureed, minced, moist)	☐	☐
- Weight reducing or weight increasing diet	☐	☐
- Diabetic or any other diet which restricts food choices?	☐	☐
7 Behave inappropriately with food, including:		
- Attempting to eat non-food items	☐	☐
- Vomiting or regurgitating food?	☐	☐
8 Exclude all foods from any of these food groups?		
- Breads, cereals, rice, pasta and noodles	☐	☐
- Fruit and vegetables	☐	☐
- Milk, yoghurt and cheese	☐	☐
- Meat, fish, poultry, eggs, nuts and legumes	☐	☐
- Fats and oils	☐	☐
9 Have any mouth or teething problems that affect their eating, including:		
- Loose, broken or missing teeth	☐	☐
- Inflamed or ulcerated lips, tongue, throat or gums?	☐	☐
10 Take more than 30 minutes to eat their meal, or appear to tire as the meal progresses?	☐	☐
11 Have a history of choking incidents, or lodged food, that required forceful coughing or first aid to clear, in the past 12 months?	☐	☐
12 Overfill their mouth or try to eat very quickly?	☐	☐
13 Swallow their food without chewing, suck their food, or leave their food in their mouth for a long time before swallowing?	☐	☐
14 Cough, gag, breathe noisily, get watery eyes or show distress during, or several minutes after eating, drinking, or taking medication?	☐	☐

Does the Person	Yes	No
15 Unintentionally vomit or bring up food, drink or medication more than once per day or on a regular basis?	☐	☐
16 Have a history of:		
- Chest infections two or more times a year that might indicate aspiration pneumonia	☐	☐
- Usually being 'chesty' or have difficulty clearing phlegm	☐	☐
- Asthma or wheezing?	☐	☐
17 Take anti-reflux medication, complain of reflux, or clear their throat or burp often?	☐	☐
18 Drool, or dribble saliva, food or drink?	☐	☐

3 Additional Comments

4 Checklist Verification

Name of Person Completing the Form

Date

Designation

Signature