Forms

Team Procedure Checklist

Student: _____ School: _____
SLP: _____ OT: _____
Nurse: _____

DATE	PROCEDURE
Step 1: Observation Request	
	Observation Request Form completed by:
	Informal Observation of the student eating, completed by:
Step 2: Caregiver Interview	
	Caregiver Interview Form sent home
	Interview with caregiver: ☐ Phone ☐ Virtual ☐ In-person ☐ Unable to meet
Step 3: Interdisciplinary Assessment	
	Interdisciplinary team completes the mealtime assessment
	Team meets to discuss outcome of the assessment and next steps
Step 4: Safe Eating Plan	
	Safe Eating Plan written
	IHP/Emergency Plan established and signed by parent
	Cafeteria staff trained on mealtime modifications as needed
	Classroom staff trained on Safe Eating Plan and Emergency Plan
	Safe Eating and Emergency Plans initiated
Step 5: School Meal Modification	
	Prescription for School Meal Modification obtained
	Safe Eating Plan is given to Child Nutrition director and staff
	Child Nutrition staff trained on IDDSI (as needed) and the student's Safe Eating Plan

DATE	PROCEDURE
Step 6: IEP Conference	
	IEP meeting held *Persons attending: ☐ Teacher ☐ SLP ☐ OT ☐ PT ☐ Administrator ☐ Nurse ☐ Parents ☐Other: _____ *Issues addressed: ☐ Emergency Plan ☐ Medical History ☐ Referral to Physician ☐ Release of Information ☐ Safe Eating Plan discussed ☐ Referral for VFSS ☐ Information from IEP sent to Food Service for recommended changes ☐ Other: _____
Step 7: VFSS Referral (as needed)	
	Script for instrumental evaluation requested from physician, when indicated
	Script received and VFSS appointment set up
	Pre-VFSS Form sent to hospital SLP
	VFSS conducted *attended by: _____
Step 8: Safe Eating Plan Revised (as needed)	
	Addendum to IEP to include new information
	Safe Eating Plan revised to reflect recommendations from the VFSS
	School staff and caregivers trained on the new Safe Eating Plan
	New Safe Eating Plan is initiated

Observation Request Form

Date form completed: _____ Classroom teacher: _____

Student: _____ Completed by/title: _____

Date of birth: _____ School: _____

BACKGROUND INFORMATION:

Medical Diagnosis: _____

History of swallowing or feeding concerns: ☐ YES or ☐ NO

If YES, please choose from the following:

☐ Repeated respiratory infections ☐ History of recurrent pneumonia ☐ Weight loss/history of undernutrition	☐ Receives nutrition through tube feeding ☐ Other:

OBSERVED BEHAVIORS:

Consult with speech-language pathologist, occupational therapist, and staff assigned to support the student during mealtimes to answer questions below.

☐ Requires special diet or diet modification (i.e. baby foods, thickener, soft food only) ☐ Poor upper body control ☐ Poor oral motor functioning ☐ Maintains open mouth posture ☐ Drooling ☐ Nasal regurgitation ☐ Food remains in mouth after meals (pocketing) ☐ Swallowing solid food without chewing ☐ Overstuffing ☐ Effortful swallowing or difficulty initiating swallow	☐ Food and/or drink escaping from the mouth or trach tube ☐ Slurred speech ☐ Eyes watering/tearing during mealtime ☐ Wet breath sounds and/or gurgly voice quality following meals or drinking ☐ Coughing/choking during meals ☐ Unusual head/neck posturing during eating ☐ Hypersensitive gag reflex ☐ Mealtime takes more than 30 minutes ☐ Needs assistance with mealtimes

ADDITIONAL ADVERSE BEHAVIORS OBSERVED:

☐ Avoids food textures, colors, tastes, etc.
☐ Feeding jags (eats only one thing)
  ☐ Limited eating (only eats a certain amount)
☐ Maintains open mouth posture
  ☐ Spitting up or vomiting associated with eating and drinking
	☐ Gags easily
	☐ Food refusal
	  ☐ Feeding aversion
	  ☐ Self-injury during meals

ADDITIONAL INFORMATION OR COMMENTS:

SECTION COMPLETED BY PFD TEAM MEMBER:

Informal observation conducted by: _____

Notes:

☐ **Concerns Verified**: **Initiate Step 2: Caregiver Interview in PFD Procedures**

Next Steps:

Caregiver Interview Form

☐ In person meeting ☐ Virtual meeting ☐ Phone
Student: _____ Gender: _____ Date of Birth: _____
Name of caregivers: _____ Phone: _____
Address: _____

_____

Do you have any concerns about your child's feeding and/or mealtimes? ☐ YES ☐ NO
If yes, please describe:

MEDICAL INFORMATION

Name of primary care physician: _____
Is your child followed by any of the following physicians?

☐ Gastroenterologist Name and Phone #: _____
☐ Neurologist Name and Phone #: _____
☐ Pulmonologist Name and Phone #: _____
☐ Other: _____ Name and Phone #: _____
Current Height: _____ **Current Weight:** _____
Indicate if your child has any of the following allergies?

☐ Food: _____
☐ Environmental: _____
☐ Asthma: _____

Bowel Habits:
Frequency of Bowel Movements: _____times per (check one): ☐ Day ☐ Week
Consistency: ☐ Hard ☐ Soft ☐ Loose ☐ Watery
Sleep patterns: ☐ Normal ☐ Wakes at night ☐ Snores ☐ Mouth breathing
Medications taken on a regular basis (please include dosage and frequency):

Medication	Dose	Prescribing Physician

Please check if your child has had any of the tests below:

☐ Swallow study (VFSS) Date: _____ Results: _____

☐ Upper GI (Barium Study) Date: _____ Results: _____

☐ Gastric emptying Date: _____ Results: _____

Does or has your child ever had GERD (gastroesophageal reflux disorder)? ☐ YES ☐ NO

If yes, please list the symptoms and treatments:

Has your child had other esophageal conditions such as eosinophilic esophagitis, or gastrointestinal disorder? ☐ YES ☐ NO

If so, when and current treatment:

Does your child currently have frequent respiratory infections? ☐ YES ☐ NO

Does your child have a history of pneumonia? ☐ YES/when? _____ ☐ NO

Has your child ever been diagnosed with undernutrition? ☐ YES/when? _____ ☐ NO

Explain how this was addressed:

Was it resolved? ☐ YES ☐ NO

Was, or is your child fed through a feeding tube? ☐ YES ☐ NO

If yes, then when? _____ How long? _____

What was the reason for the tube feeding?

☐ Aspiration ☐ Undernutrition ☐ Other: _____

Hospitalizations (month, year, reason):

Current Medical Problems:

Does the child visit the dentist on a regular basis? ☐ YES ☐ NO

When was your child's last visit to the dentist? Date: _____

Dentist Name: _____

Is there any significant dental history that may affect your child's eating habits? ☐ YES ☐ NO

If yes, please explain:

Tooth brushing: ☐ with assistance ☐ independent

CURRENT FEEDING PRACTICES

Describe a typical family meal:

What are your child's food preferences?

Likes:

Dislikes:

What kinds of food does your child eat?

☐ Regular Liquids ☐ Thickened liquids ☐ Pureed ☐ Mashed ☐ Ground
☐ Chopped ☐ Bite-sized pieces ☐ Table foods (whatever your family is eating)

Does your child self-feed (e.g., holding utensil, scooping, bringing food to mouth)?

☐ YES, independently ☐ YES, with assistance ☐ NO

Does your child enjoy mealtime? ☐ YES ☐NO

Are mealtimes stressful for the child and/or caregiver? ☐ YES ☐ NO

How do you know when your child is hungry?

How do you know when your child is full?

Frequency and duration of meals:

Check all that apply:

☐ Choking during a meal ☐ Vomiting ☐ Coughing during and/or after a meal
☐ Chronic ear infections ☐ Gagging ☐ Chronic respiratory problems
☐ Difficulty chewing ☐ Tongue thrust ☐ Gurgly or "wet" voice
☐ Biting on utensils ☐ Food refusal ☐ Sensitive to being touched around the mouth
☐ Avoidance behaviors during feeding
☐ Drooling: ☐ constant ☐ frequent ☐ occasional

Does your child take any nutritional supplements? ☐ YES ☐ NO

If yes, specify: _____

Do certain foods/liquids appear to be more difficult for your child to eat?

How is your child positioned during feeding?

☐ Regular chair at table ☐ Booster seat ☐ Highchair
☐ Sitting in a wheelchair ☐ Tumble form chair ☐ Held on lap
☐ Adaptive chair, type: _____
☐ Other: _____

What utensils are used?

☐ Bottle ☐ Sippy cup ☐ Open Cup (no lid) ☐ Straw
☐ Spoon ☐ Fork ☐ Toddler utensils

Other adaptive equipment:

Additional Comments or Concerns:

_____ _____
CAREGIVER SIGNATURE **DATE**

_____ _____
CAREGIVER'S NAME PRINTED **PHONE #**

_____ _____
INTERVIEWED BY **DATE**

Interdisciplinary Assessment Form

Student: _____ **Age:** _____ **Date of Birth:** _____ **Date of Observation:** _____
School: _____ **Diagnosis:** _____
SLP: _____ **OT:** _____ **Classroom Teacher:** _____
Nurse: _____ **Parent:** _____ **PT:** _____

General Information
During this consultation, the student was (check all that apply):
Level of Alertness: _____
Level of Awareness: _____
Mode of Communication: _____

Seating: ☐ Wheelchair ☐ Tumble form ☐ Rifton Chair ☐ Other: _____

Positioning: ☐ Upright ☐ Semi upright ☐ Reclining <30º
☐ Other: _____

Head control: ☐ Adequate ☐ Poor ☐ Excessive head/neck hyperextension

Facial: ☐ Asymmetrical ☐ Jaw extension ☐ Open mouth posture

Abnormal reflexes observed:

Notes:

Observation of Liquids Presented: ☐ **N/A**

1. Method of Presentation (ex: straw, etc.): _____
2. Oral Presentation (lateral vs. midline): _____
3. Pacing and Cueing Description: _____
4. Manual Support**:** _____

Instructions: Write in the name of the liquid presented in the blocks labeled liquid 1, liquid 2 and liquid 3. Check all that apply.

	Liquid 1:	Liquid 2:	Liquid 3:
Consistency of Liquid			
Temperature			
Taste (Sour, Sweet, etc.)			
Tongue Thrust/ reduced retraction	☐	☐	☐
Bite on cup	☐	☐	☐
Anterior loss	☐	☐	☐
Limited jaw opening	☐	☐	☐
Limited upper lip closure over cup	☐	☐	☐
Delayed swallow	☐	☐	☐
Coughing following drink	☐	☐	☐
Gurgly, wet quality (check those that apply)	☐ Before ☐ During ☐ After	☐ Before ☐ During ☐ After	☐ Before ☐ During ☐ After
Liquid residue in oral cavity	☐	☐	☐
Throat clearing	☐	☐	☐
OTHER:	☐	☐	☐

Observation of Foods Presented ☐ **N/A**

1. Method of Presentation (ex: spoon, etc.): _____
2. Oral Presentation (lateral vs. midline): _____
3. Pacing and Cueing Description: _____
4. Manual Support: _____

Person assisting with meal: _____ **Location/Setting:** _____ **Positioning:** _____

Utensils/Adaptive equipment used: _____

Instructions: Write in the name of the food presented in the blocks labeled food 1, food 2 and food 3. Check all that apply.

	Food 1:	**Food 2:**	**Food 3:**
Consistency of food presented:			
Temperature:			
Taste (Sour, savory, etc.)			
Poor lip closure	☐	☐	☐
Drooling	☐	☐	☐
Reduced lip action to clear material	☐	☐	☐
Poor bolus formation/movement	☐	☐	☐
Decreased anterior/posterior movement	☐	☐	☐
Food residue in oral cavity	☐	☐	☐
Absence of chewing	☐	☐	☐
Absence of rotary jaw movement (munching)	☐	☐	☐
Bites on spoon or utensil	☐	☐	☐
Delayed swallow initiation	☐	☐	☐
Cough or throat clear following swallow	seconds	seconds	seconds
Cued swallow	☐	☐	☐
Fatigued easily	☐	☐	☐
Gagging before/during/after meal	☐	☐	☐
OTHER:	☐	☐	☐

Behavioral Observations ☐ **N/A**

Instructions: Briefly describe how the food was presented and what happened under each presentation. Check + if the behavior was observed and – if the behavior was not observed. Ex: sweet, crunchy

Interfering Behaviors	Liquid #1	Liquid #2	Liquid #3	Food #1	Food #2	Food #3
Throwing food/utensils	☐	☐	☐	☐	☐	☐
Screaming/crying	☐	☐	☐	☐	☐	☐
Self-injury	☐	☐	☐	☐	☐	☐
Flopping (falling to the floor)	☐	☐	☐	☐	☐	☐
Leaving the area	☐	☐	☐	☐	☐	☐
Closing mouth/head turn	☐	☐	☐	☐	☐	☐
Talking with food in mouth	☐	☐	☐	☐	☐	☐
Spitting	☐	☐	☐	☐	☐	☐
Overstuffing	☐	☐	☐	☐	☐	☐
Aggression (biting, scratching, head butting, punching attempting to hurt feeder)	☐	☐	☐	☐	☐	☐
OTHER:	☐	☐	☐	☐	☐	☐

Sensory Questionnaire and Observation ☐ **N/A**

Instructions: Observe and interview teachers, parents etc. and indicate if each statement applies. Add comments to explain further.

Sensory Questionnaire/Observation	**Check all that apply**	**Additional comments:**
Avoids eating certain food textures (crunchy, soft, chewy, liquid)	☐	
Avoids eating foods of certain temperatures (warm like oatmeal, cold like ice, room temperature)	☐	
Eats primarily one color of food	☐	
Eats only certain tastes (salty, sweet, sour, spicy, bland)	☐	
Does not notice food left on his/her face	☐	
Reacts emotionally when asked to hold utensil/cup	☐	
Limits self to specific food items - list	☐	
Gags when introduced to a new food or texture	☐	
Gags easily when eating or when using utensils	☐	
Resists tactile exploration of food or other activities (sand, mud, play doh, etc.)	☐	
Enjoys playing with food but does not eat it	☐	
Resists grooming, face washing, tooth brushing	☐	
Mouths, licks, or chews non-edible items	☐	
Routinely smells things (food or non-food items)	☐	
Hypersensitive to noises in the environment	☐	
Overstuffing	☐	

Modifications Attempted During Interdisciplinary Observation

Dietary Modifications: _____

Adapted Equipment Modifications: _____

Positional Changes: _____

Behavioral Interventions: _____

Other: _____

Summary and Recommendations:

1. _____
2. _____
3. _____

Date Parent Informed: _____

Date Team Informed: _____

Parent/Team Additional Notes:

Referral/Recommendation for:

☐ VFSS ☐ Physician Consultation ☐ Release of Information ☐ Behavioral Specialist Referral
☐ Safe Swallowing and Feeding Plan ☐ Training ☐ IEP team meeting scheduled

_____ _____

Signature of Person Completing Form Date

Safe Eating Plan

Student: _____ Date of Birth: _____
School: _____ Date of Plan: _____
Teacher: _____ PFD Team Lead: _____
PFD Team Lead Contact Info: _____

CASE HISTORY AND PRESENTING CONCERNS:
Diagnosis: _____
Findings from VFSS and/or Interdisciplinary observation:

_____
Seizure Disorder: ☐ Yes ☐ No

FEEDING RECOMMENDATIONS:

Seating and Positioning: _____
Positioning of the feeder to the student:

☐ Feeder directly across from student ☐ Feeder slightly to the side of student
☐ Feeder next to the student ☐ Other:

Utensil selection (type in specific recommendation):

☐ Special spoon/fork
☐ Special cup
☐ Special bowl/plate
☐ Other: _____

Tube Feeding:

☐ Tube fed only/nothing by mouth
☐ Tube and oral fed

Diet/Food Preparation (according to the IDDSI):

Food Consistency:

☐ Liquidized ☐ Pureed (pureed) ☐ Minced and moist (mech. ground)
☐ Soft and bite sized (chopped) ☐ Regular (regular)

Liquid Consistency:

☐ Extremely Thick (pureed) ☐ Moderately thick (honey)
☐ Mildly thick (nectar) ☐ Slightly thick ☐ Thin

Sensory Modifications:

☐ Temperature: _____ ☐ Taste: _____
☐ Texture: _____ ☐ Color: _____

Other recommendations:

Feeding Plan Techniques/Precautions:

Amount of food per bite (be specific to amount and size): _____

Spoon presentation and placement: ☐ Left Lateral ☐ Right Lateral ☐ Midline

Keep the student in an upright position for _____ minutes after the meal.

Offer a drink after _____ bites.

- Amount of liquid required: _____

Typical volume consumed during the meal: _____

Other mealtime management precautions:

Monitoring during mealtimes:

☐ 1:1 feeder to student ☐ 1:2 feeder to student ☐ 1:3 feeder to student

Swallowing and Feeding Plan Training

I, the undersigned, have read and been trained on implementing the swallowing and feeding plan for _____. I agree to implement the swallowing and feeding plan as specified.

Name	Position	Date

I understand that I am responsible for the implementation of this student's Safe Eating Plan.

Teacher Signature: _____ **Date:** _____

Trained Feeders

Student: _____ Classroom Teacher: _____

PFD Team Leader: _____ School: _____

Use this form to document the date, supervision, and names of feeders trained. Document comments as necessary. An example is provided.

Indicate the level of supervision and monitoring required during meals at school using the following key:

1:1 Student needs maximum monitoring during meals. One student to one trained adult.

2:1 Student needs monitoring during meals but is somewhat independent. Two students to one trained adult.

3:1 Student self feeds and needs to be monitored during meals to maintain pacing, food choices, drink to food ratio, etc. Three students to one trained adult.

Date	Level of Supervision	Feeder #1	Feeder #2	Feeder #3	Comments
Example: 08/31/2023	*1:1*	*Ms. Smith*	*Ms. Adams*	*Mr. Owens*	*Initial training on Safe Feeding Plan*
Example: 12/01/2023	*2:1*	*Ms. Smith*	*Ms. Adams*	*Mr. Owens*	*Training on **Revised** Safe Feeding Plan*

School Meal Modification Form

Student's Name: _____ Age: _____ Grade/Classroom: _____
School: _____ Parent's Name: _____
Parent's Email: _____ Telephone: _____
Address: _____
Steet or P.O. Box City Zip

List the Medical Condition that results in special nutritional or feeding needs:

_____

DIET PRESCRIPTION (mark all that apply)

Food Intolerance: _____

Eliminate ALL foods that may contain any form of:

- ☐ Eggs-pure form only
- ☐ Milk-beverage form only*
  *Substitute (please check): ☐ Juice or ☐ Water
- ☐ Milk AND dairy only*
  *Substitute (please check): ☐ Juice or ☐ Water
- ☐ Eggs proteins
- ☐ Fish
- ☐ Milk proteins
- ☐ Nuts
- ☐ Peanuts
- ☐ Shellfish
- ☐ Soy-pure form only
- ☐ Soy
- ☐ Wheat-whole form only
- ☐ Wheat
- ☐ Other: _____

Consistency: Foods

- ☐ Regular
- ☐ Soft and bite-sized
- ☐ Minced and Moist
- ☐ Pureed/Extremely thick
- ☐ Liquidized

Consistency: Drinks

- ☐ Thin
- ☐ Slightly thick
- ☐ Mildly thick
- ☐ Moderately thick
- ☐ Extremely thick

Any Other Specific Dietary Need: _____

Specific Foods to Omit	Specific Foods to Substitute
_____	_____
_____	_____
_____	_____

Please note: if juice or water must be substituted for liquid milk, it must be noted on diet prescription form or student will be charged for juice or water.

I certify that the above-named student needs special meals prepared as described above because of the student's chronic medical condition:

Office Address: _____
Office Fax: _____ Office Telephone: _____

_____ _____
Licensed Physician/Recognized Medical Authority Signature Date

Instrumental Evaluation Form

Date form completed: _____

Name: _____ Date of Birth: _____ CA: _____

Diagnosis: _____

Referring SLP: _____

BRIEF MEDICAL HISTORY:

Positional concerns and adaptive equipment currently used at school:

Current diet recommendations: _____

Results of Interdisciplinary Observation Performed at School:

Oral Phase:

☐ Drooling ☐ Pocketing: ☐ Lateral sulcus ☐ Anterior sulcus ☐ Not clearing the oral cavity before swallow ☐ Anterior loss/poor lip seal	☐ Excessive chewing ☐ Hyper/hypo sensitivity ☐ Difficulty with bolus formation ☐ Other:

Pharyngeal Phase:

☐ Coughing/choking: ☐ Before ☐ After ☐ During swallow ☐ Repetitive swallows ☐ Wet/gurgly voice quality after swallow	☐ Delay in triggering swallow ☐ Decreased/absent laryngeal elevation ☐ Expectorating food ☐ Other:

Information that the school system would like to receive from the instrumental evaluation:

1. _____
2. _____
3. _____

We have included an Authorization for Release of Confidential Information. If you have questions, please contact:

Name: _____ Phone: _____

Email: _____

PFD School Transfer Form

Please complete this form on any student who will be moving or has moved to a new school. Put a copy of this form in the student's folder and send a copy of this transfer form to the pediatric feeding disorders team administrator. Complete a different form for each student who is transferring to a different school.

Date: _____

Name of Student: _____ Date of Birth: _____

Current School: _____

Current PFD Team Leader: _____

School Transferring to: _____

Receiving PFD Team Leader: _____

*Note: Use the Pediatric Feeding Disorder Team Assignment Form to determine who the PFD Team Leader is for the receiving school.