RESIDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STAFF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEAL PERIOD: \_\_\_\_ Breakfast \_\_\_\_ Lunch \_\_\_\_ Dinner

SNACK PERIOD: \_\_\_\_ Morning \_\_\_\_ Afternoon \_\_\_\_ Evening

Resident was experiencing (Check all that Apply):

\_\_\_\_\_ Refusing to eat

\_\_\_\_\_ Difficulty chewing or swallowing

\_\_\_\_\_ Pocketing food

\_\_\_\_\_ Coughing associated with swallowing

\_\_\_\_\_ Increased drooling

\_\_\_\_\_ Changes in speech

\_\_\_\_\_ Nausea/ vomiting

\_\_\_\_\_ Increased confusion

\_\_\_\_\_ Increased agitation

\_\_\_\_\_ Unusual drowsiness

\_\_\_\_\_ Pain (Indicate Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_\_\_ Other (Describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please give this form to the charge nurse who will decide if it needs to be shared with others such as the dietitian, speech therapist, occupational therapist, etc.*

RESIDENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STAFF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEAL PERIOD: \_\_\_\_ Breakfast \_\_\_\_ Lunch \_\_\_\_ Dinner

SNACK PERIOD: \_\_\_\_ Morning \_\_\_\_ Afternoon \_\_\_\_ Evening

Resident was experiencing (Check all that Apply):

\_\_\_\_\_ Refusing to eat

\_\_\_\_\_ Difficulty chewing or swallowing

\_\_\_\_\_ Pocketing food

\_\_\_\_\_ Coughing associated with swallowing

\_\_\_\_\_ Increased drooling

\_\_\_\_\_ Changes in speech

\_\_\_\_\_ Nausea/ vomiting

\_\_\_\_\_ Increased confusion

\_\_\_\_\_ Increased agitation

\_\_\_\_\_ Unusual drowsiness

\_\_\_\_\_ Pain (Indicate Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_\_\_ Other (Describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please give this form to the charge nurse who will decide if it needs to be shared with others such as the dietitian, speech therapist, occupational therapist, etc.*