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.*