ORTHONET
DYSPHAGIA EVALUATION

Member/ID#: Insurance Company:
Provider: Provider #:
Medical Diagnosis: ICD-9 Code:
Date of Birth: Age:
Date of Onset: Date of Evaluation:

Reason for Referral:

Previous Status:

Medical History (Include any history of Dysphagia, Aspiration, and/or Pneumonia):

Current Diet/Liquid Consistency: Dietary Restrictions:
Nutritional Status: Feeding Method:
Weight Change:

Respiratory Status: Positioning and Mobility:

Cognitive Status:

**Oral Peripheral Exam:**

<table>
<thead>
<tr>
<th></th>
<th>Structure</th>
<th>Function</th>
<th>Sensation</th>
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</thead>
<tbody>
<tr>
<td>Facial</td>
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<tr>
<td>Lips</td>
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<tr>
<td>Tongue</td>
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<tr>
<td>Jaw</td>
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<tr>
<td>Hard Palate</td>
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<tr>
<td>Soft Palate</td>
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<td>Uvula</td>
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<tr>
<td>Dentition</td>
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</table>
Pharyngeal Exam:

<table>
<thead>
<tr>
<th>WFL</th>
<th>Impairment</th>
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<tbody>
<tr>
<td>Volitional Cough</td>
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<tr>
<td>Volitional Swallow</td>
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<tr>
<td>Gag Reflex</td>
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<tr>
<td>Soft Palate Function</td>
<td></td>
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<tr>
<td>Vocal Quality</td>
<td></td>
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</tbody>
</table>

Comments:

Trial Consistencies:
Thin___  Nectar___ Honey___ Pudding___
Regular___Bite size___Chopped___Mechanical Soft___Ground___Puree___Pudding___

Oral Preparatory Phase:
Lip seal via spoon/cup:  WFL___ Impaired___
Bolus Containment:  WFL___ Impaired___

Oral Stage:
Bolus Formation:  WFL___ Impaired___
Bolus Propulsion:  WFL___ Impaired___
Bolus Accumulation:  WFL___ Impaired___
Mastication:  WFL___ Impaired___

Pharyngeal Stage:
Laryngeal Elevation:  WFL___ Impaired___
Vocal Quality after swallow: _______________________
Swallow Reflex Time: ______ # of Swallows ______
Coughing: No___ Yes ___ Before Swallow___ During Swallow___ After Swallow___

Esophageal Stage:
Nasal Regurgitation___
Oral Regurgitation___
C/O Fullness Around Sternum___

Signs/Symptoms of Aspiration (please specify):
Clinical Summary:

Recommended Diet/Liquid Consistency:

Recommended Referral(s):

Recommended Adaptive Equipment (please specify):

Plan of Treatment (check all that apply):
- Aspiration Precautions
- Reflux Precautions
- Therapeutic Feeding Sessions
- Compensatory Strategies for Safe Swallowing
- Therapeutic Exercises
- Therapeutic Activities
- Other:

Long Term Goals:
1.

2.

Short Term Goals:
1.

2.

3.

4.

5.

Requested # of Visits: 
Frequency/Duration of Treatment:

SLP Printed Name: ____________________________________________

SLP Signature/License #:________________________________________