

1. Information about the person

First name:		Family name:		Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Other <input type="checkbox"/>
Age:	0-5 <input type="checkbox"/>	6-18 <input type="checkbox"/>	19-39 <input type="checkbox"/>	40-54 <input type="checkbox"/>	55+ <input type="checkbox"/>	Telephone:	
Address:							

2. Eating and drinking screen

Ask if the person can:			
Sit upright (with or without support?)		Yes: With support <input type="checkbox"/> Yes: Without support <input type="checkbox"/> No <input type="checkbox"/>	If no to any, the person may need specialised eating and drinking aids and other support ☞ Do not continue assessment, and refer to a health professional
Hold head upright and steady (with or without support?)		Yes: With support <input type="checkbox"/> Yes: Without support <input type="checkbox"/> No <input type="checkbox"/>	
Chew and swallow food without coughing or choking?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Swallow liquid without coughing or choking?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Eat and drink without food or drink spilling from mouth or nose?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Eat and drink without any pain?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Eat and drink without getting out of breath?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Ask about health and nutrition risks:			
Weight	Are you underweight (thin)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes to any, ☞ Complete the assessment and refer to a health professional for a health check
	Have you recently lost weight?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Do you have difficulty putting on weight?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Do you have poor appetite?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Does it take a long time to chew and swallow (mealtime takes more than 30 minutes?)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Airway	Have you had a chest infection in the past six months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. Assessment interview

Ask: What difficulties do you have with eating and drinking?			
If the person has assistance to eat or drink, discuss including their caregiver in the assessment interview.			
Physical You may ask the person to show you these actions: • Pick up an object (pen) • Bring hand to mouth	Picking food up (with hands or cutlery)	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes to any, eating and drinking aids may help. If difficulties are not addressed by the eating and drinking aids ☞ refer to a health professional.
	Getting food into bite sized pieces	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Getting food into mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Picking up cups	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Getting liquid into the mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Vision	Finding food on the plate or table, finding the cup or bottle to drink from	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, discuss possible solutions (see selection table) and/or ☞ refer to a vision service or health professional
Thinking	Planning or remembering to eat and drink	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, other assistive products may help. Discuss possible solutions (see selection table)

4. Plan

Select and try:	
Eating aid	Modified cutlery <input type="checkbox"/> Type: <input type="text"/> Cuff <input type="checkbox"/> High sided plate <input type="checkbox"/> High sided bowl <input type="checkbox"/> Non-slip mat <input type="checkbox"/>
Drinking aid	Cup with two handles <input type="checkbox"/> Cup with non-spill lid and handles <input type="checkbox"/> Cut away cup <input type="checkbox"/> Straw <input type="checkbox"/>
Teach about:	Using the eating or drinking aid <input type="checkbox"/> Cleaning and care of eating and drinking aid <input type="checkbox"/>
Refer to:	Health professional <input type="checkbox"/> Rehabilitation service <input type="checkbox"/> Vision service <input type="checkbox"/> Other assistive product <input type="checkbox"/> Type: <input type="text"/>
	Follow up date: <input type="text"/>