Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PARIS PRIMARY ACCESS Regional Information System

DYSPHAGIA SCREENER

Name:		**PARIS ID:**
DOB:	**Age:**	**PHN:**
Gender:		**Phone:**
Home Address:		

Assessment Start Date: **Assessment End Date:** **Carried Out By:**

Medical Conditions

Medications

Please see Medication Section in PARIS or Medication/Treatment Orders-Recommendation report for further details. (eg. medications in home?, Confirmed (written order received?))

Medication	Route	Dose	Frequency	Start Date	End Date	Comments

Diagnosis

Date	Diagnosis Type	Diagnosis	State	Aware?	Comments

Screening

Immediate Referral to a physician for acute management, for one or more of the following:

- ☐ Persistent Vomiting
- ☐ Acute abdominal pain
- ☐ Acute respiratory distress
- ☐ Symptoms/signs of dehydration
- ☐ <50% of usual intake (for >= 3 days or if <= 3 years of age)

Physical/Cognitive Status: Check all that apply and indicate if less than 6 months

	Applies	Less than 6 months
Alert and Oriented	☐	☐
Distractible	☐	☐
Confused	☐	☐
Lethargic	☐	☐

DYSPHAGIA SCREENER

Name:	PARIS ID:

Hearing/Visual Defects	☐	☐
Uncooperative	☐	☐
Follows simple commands	☐	☐
Verbal	☐	☐
Nonverbal	☐	☐
Uses alternative communication system	☐	☐

Community Referral: If a swallowing problem is suspected, ask the client/care provider to respond to the statements below. Indicate if this is a recent problem (less than 6 months).

	Applies	Less than 6 months
1. Recurrent respiratory problems	☐	☐
2. Difficulty swallowing liquids	☐	☐
3. Difficulty swallowing foods	☐	☐
4. Consistently coughs/chokes/clears throat while eating and drinking	☐	☐
5. Gurgly breathing/voice quality before or after eating	☐	☐
6. Eyes water, facial colour changes, nose runs while eating/drinking	☐	☐

If any of symptoms 1-6 are present, the referral should be considered to be high priority. Prioritize this referral according to risk and urgency following a discussion between the referral source, the Vancouver Community A/OA Occupational Therapist and Nutritionist/ Speech-Language Pathologist.

7. Recently changed eating habits	☐	☐
8. Excessive drooling	☐	☐
9. Recent weight loss (for children, poor growth)	☐	☐
10. Takes more than 45 minutes to eat a meal	☐	☐
11. Difficulty with eating independently	☐	☐
12. Has problems with dentition	☐	☐

Needs

Need	Post to C/P	Processed	Comments

Casenotes

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

---------- End of Report ----------