**Meal Time Feedback Form**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Volunteer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patients Diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Oral Hygiene Completed: Yes No**

**Oral Cavity Findings: mouth sores abnormal dentition excess coating on tongue**

**excess phlegm**

**What did the patient take and how much (%)**

* **Liquids \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Food \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Observations:**

**\*If you have 4 check marks in the boxes immediately below, discontinue feeding and contact the patient’s nurse and the ELS\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Throat Clearing** | **Coughing** | **Gurgly Voice** | **C/O of food sticking** |

**Level of Alertness:**

|  |  |  |
| --- | --- | --- |
| **Alert for the entire meal** |  **Drowsy (If yes, STOP feeding)** |  **Refused meal** |

**Other observation (check as many as apply):**

|  |  |  |
| --- | --- | --- |
| **Food/liquid falling** **from mouth** | **Food/drink in the** **mouth after swallow** | **Holding the food/drink** **in the mouth** |
| **Complaining of pain** | **Spitting food/drink out** | **Swallowing more than 3 times per bite/sip** |

**Nurse required to be notified: Yes No**