REHABILITATION SERVICES - TOR-BSST SWALLOWING MONITORING RECORD

This Swallowing Monitoring Record is for use with acute stroke patients who have passed the TOR-BSST swallowing screening test. Please observe during the first three meals provided to the patient and note your observation below.

Observations

Please check under appropriate meal, if any of the following difficulties are observed.

	_____ date ☐Breakfast ☐Lunch ☐Dinner	_____ date ☐Breakfast ☐Lunch ☐Dinner	_____ date ☐Breakfast ☐Lunch ☐Dinner
DURING MEAL THE PATIENT:			
Was unable to take food from a spoon or drink from a cup without spillage from lips/drooling	☐	☐	☐
Pocketed food in cheek	☐	☐	☐
Choked	☐	☐	☐
Was coughing	☐	☐	☐
Was unable to chew diet consistency	☐	☐	☐
Had difficulty moving food in their mouth	☐	☐	☐
Had a noticeable change in their voice when eating or drinking (wet, gurgly, hoarse)	☐	☐	☐
Had breathing difficulty	☐	☐	☐
Was impulsive, had poor judgement or was distractible	☐	☐	☐
Had other difficulty (please describe):	☐	☐	☐
Patient had NO swallowing related difficulty during the meal	☐	☐	☐
AFTER THE MEAL THE PATIENT:			
Was coughing	☐	☐	☐
Had a noticeable change in their voice (wet, gurgly, hoarse)	☐	☐	☐
Had difficulty breathing	☐	☐	☐
Complained of food sticking	☐	☐	☐
Had excess food reside in mouth (pocketed in cheek, etc.)	☐	☐	☐
Had other difficulty (please describe):	☐	☐	☐
Patient had NO swallowing related difficulty after the meal	☐	☐	☐
PRINT ON ORANGE PAPER	_____ initials	_____ initials	_____ initials

If any swallowing difficulty is noted during or after meals, please make NPO and request physician referral to Speech-Language Pathology for a swallowing assessment.