Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
*Caring for Health* | *À l'écoute de notre santé*

# Home Care Swallowing Screen

**Client Health Record #**
**Client Surname**
**Given Name**
**Date of Birth**
**Gender**
**MFRN**
**PHIN**
**Address**

| **To what extent do you experience the following problems?**<br>A total score of 2 or less does not require further action be taken at this time. A total score of 3 or more requires further swallowing assessments be completed. | ***Assessor to mark the value indicated by the clients response***<br>**0 = No problem** **4 = severe problem** | | | | |
|---|---|---|---|---|---|
| | **0** | **1** | **2** | **3** | **4** |
| 1. My swallowing problem has caused me to lose weight. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. My swallowing problem interferes with my ability to go out for meals. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Swallowing liquids takes extra effort. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Swallowing solids takes extra effort. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Swallowing pills takes extra effort. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Swallowing is painful. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. The pleasure of eating is affected by my swallowing. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. When I swallow food sticks in my throat. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. I cough when I eat. | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Swallowing is stressful. | ☐ | ☐ | ☐ | ☐ | ☐ |

Subtotals: _____ + _____ + _____ + _____ + _____

**TOTAL SCORE:** _____
(out of 40)

**If the total score is 3 or more, complete one of the following**; Indicate which action was taken

☐ The client is affiliated with a clinic that provides swallowing assessments; for example, Movement Disorders clinic, Cancer Care. A copy of the Home Care Swallowing Screen has been faxed to inform the client's team at the clinic.

Clinic Name _____ Phone |_|_|_|-|_|_|_|-|_|_|_|_| Fax |_|_|_|-|_|_|_|-|_|_|_|_|

☐ The client is NOT affiliated with a clinic but is able to be mobilized to a hospital for an out-patient swallowing assessment. A referral for an outpatient Speech Language Pathology swallowing assessment is required, to be arranged by the prescriber identified below.

☐ The client cannot be mobilized to a hospital for an outpatient swallowing assessment. A referral has been sent to Community Therapy Services for a swallowing assessment.

**Fax a copy of the completed Home Care Swallowing Screen to the prescriber**

Prescriber Name _____ Phone |_|_|_|-|_|_|_|-|_|_|_|_| Fax |_|_|_|-|_|_|_|-|_|_|_|_|

**Completed by:**

Signature _____ Printed Name and Designation _____ Date |_|_|_|_|_|_|_|_| D D M M M Y Y Y Y

***Adapted from the Eating Assessment Tool (EAT-10)***
***Source: Belafsky et al (2008). Validity and Reliability of the Easting Assessment Tool (EAT-10). Annals of Otology and Rhinology & Laryngology, 117(12) 919-924.***