SLP Dysphagia Documentation Pack

Fillable PDF forms for speech-language pathologists (SLPs) who work with adults in a skilled nursing facility (SNF) or in home health. Also usable in subacute rehab.

WHAT'S INSIDE

- Clinical / bedside swallow evaluation (2 pages)
- Oral mechanism exam
- Diet and liquid recommendation
- Tray card
- Bedside or home sign
- Diet-order change notice
- Re-evaluation and progress
- Discharge recommendations
- Instrumental (MBS/FEES) referral and rationale
- Skilled documentation tips (2 pages)
- Starter goal bank

HOW TO USE THIS PACK

1. Type in the fillable PDF, or print a form and write by hand.
2. Use the evaluation and recommendation forms at the bedside or on a home visit.
3. Enter needed information into the electronic record, following facility or agency policy. These PDFs do not replace the official record.
4. Give the tray card, the bedside or home sign, and the diet-order change notice to the team when a plan is set or changed.
5. Use the tips page and goal bank as optional starting points when you write your own notes and goals. Edit every example so it matches the person in front of you.

Do not change a person's food or drink plan on a form alone. Follow facility or agency order procedures.

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NOTICES

These forms are tools for the SLP. They are not a substitute for clinical judgment, a complete evaluation, a diet order, or the official medical record. They are designed to support skilled documentation. They do not guarantee payment, coverage, or compliance with Medicare or any other payer. Follow facility or agency policy, current payer rules, and your own clinical judgment.

> These are NOT official IDDSI resources, educational materials or education programs and they are NOT meant to replace materials and resources on www.IDDSI.org.

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This pack is based on the IDDSI framework. Do not use the IDDSI logo, or "IDDSI certified," "IDDSI compliant," or "IDDSI approved." For official level names, testing methods, and consumer handouts, see https://iddsi.org/framework.

Food texture and drink thickness are separate orders. Facility words such as chopped, ground, nectar, or honey are not automatic IDDSI equivalents.

Clinical / bedside swallow evaluation

Patient / resident _____ **Date of birth** _____ **Record #** _____

Date _____ **Time** _____ **Location / room** _____ **SLP** _____

Setting ☐ SNF ☐ Home health ☐ Other: _____

Referring provider _____

Reason for referral _____

CHART REVIEW AND HISTORY

Relevant diagnoses / medical history

Prior swallowing problem ☐ No ☐ Yes ☐ Unknown

Notes _____

Prior instrumental swallow exam ☐ None known ☐ MBS / VFSS ☐ FEES ☐ Unknown

Date (if known) _____ **Findings (if known)** _____

Current food order _____ **Current drink order** _____

☐ NPO (nothing by mouth) ☐ Alternative nutrition / hydration (describe): _____

Dentition ☐ Natural ☐ Partial ☐ No teeth Dentures ☐ in ☐ out ☐ not available

Oral care concerns _____

Respiratory status / oxygen _____

Recent pneumonia or respiratory infection ☐ No ☐ Yes ☐ Unknown **Notes** _____

Intake, weight, or hydration concerns _____

Allergies / diet restrictions (non-texture) _____

Feeding-related orders or advance-care notes, if any _____

Cognition / communication (alertness, following directions, yes/no reliability) _____

Patient or family concerns _____

Usual food and drink at home, if known _____

READINESS FOR TRIALS

Alertness at the time of the exam ☐ Alert ☐ Drowsy but arousable ☐ Not alert enough for trials ☐ Variable

☐ Positioning for the exam is safe to proceed, per the care plan.

☐ Trials completed today.

☐ Trials deferred. Reason: _____

If trials are deferred, skip to Impressions and plan on side 2.

Clinical / bedside swallow evaluation, continued

Patient / resident _____ **Date** _____

BASELINE OBSERVATIONS (BEFORE TRIALS)

☐ Voice sounds clear ☐ Voice sounds wet or gurgly ☐ Voice not judged

Volitional cough ☐ Strong ☐ Weak ☐ Unable ☐ Not tested

Secretions ☐ Managed ☐ Increased **Notes** _____

Oral hygiene ☐ Adequate ☐ Needs care **Notes** _____

LIQUID TRIALS

Record item / level (use the official IDDSI name if a level is used; facility words are not automatic equivalents), amount, how it was given (spoon, cup, straw, or other), signs, and notes.

Signs (check all that apply):

☐ None observed ☐ Cough (immediate) ☐ Cough (delayed) ☐ Wet or gurgly voice ☐ Shortness of breath

☐ Change in color or distress ☐ Oral residue ☐ Patient reported food or drink remaining ☐ Other: _____

	ITEM / LEVEL	AMOUNT	GIVEN BY	SIGNS	NOTES
TRIAL 1					
TRIAL 2					
TRIAL 3					
TRIAL 4					

FOOD TRIALS

Use the same sign list. How given: spoon, fork, finger food, or other.

	ITEM / LEVEL	AMOUNT	GIVEN BY	SIGNS	NOTES
TRIAL 1					
TRIAL 2					
TRIAL 3					
TRIAL 4					

IMPRESSIONS AND PLAN

Clinical impressions (bedside findings only; this exam cannot rule aspiration in or out):

Oral intake today

☐ Continue or start oral intake, as specified on the Diet and liquid recommendation form

☐ Limit oral intake, as specified on that form

☐ NPO until further assessment or a new order

☐ Other: _____

Next steps (check all that apply)

☐ Written diet and liquid recommendation completed

☐ Staff or family education completed (who): _____

☐ Re-evaluate by (date): _____

☐ Refer for instrumental exam (complete the referral form): ☐ MBS / VFSS ☐ FEES

☐ Coordinate with the physician, dietitian, or nursing

☐ Other: _____

SLP signature / credentials as required by the facility _____ **Date** _____

Oral mechanism exam

Patient / resident _____ **Date of birth** _____

Date _____ **SLP** _____

Used

☐ With the clinical swallow evaluation

☐ As a stand-alone exam

Rate each item: WNL (within expected limits), Impaired, or Not tested. Add a short note if impaired or not tested.

ITEM	WNL	IMPAIRED	NOT TESTED	NOTES
Face symmetry, movement	☐ WNL	☐ Impaired	☐ Not tested	_____
Jaw open, close, strength	☐ WNL	☐ Impaired	☐ Not tested	_____
Lips seal, retract, protrude, strength	☐ WNL	☐ Impaired	☐ Not tested	_____
Tongue range, strength, coordination	☐ WNL	☐ Impaired	☐ Not tested	_____
Soft palate elevation, symmetry	☐ WNL	☐ Impaired	☐ Not tested	_____
Dentition and dentures	☐ WNL	☐ Impaired	☐ Not tested	_____

Dentures ☐ In ☐ Out ☐ Not available ☐ Not used **Fit / comfort** _____

Oral mucosa, hygiene, and secretions	☐ WNL	☐ Impaired	☐ Not tested	_____
Voice quality; sustained phonation if tried	☐ WNL	☐ Impaired	☐ Not tested	_____
Volitional cough	☐ WNL	☐ Impaired	☐ Not tested	_____

Additional notes (including cranial nerve notes, if relevant)

SLP signature / credentials as required by the facility _____ **Date** _____

Diet and liquid recommendation

Patient / resident _____ **Date of birth** _____ **Record #** _____

Date _____ **Time** _____ **Setting / room** _____ **SLP** _____

Food and drink are separate orders. If you select an IDDSI level, use the official name. This form is based on the IDDSI framework; it is not an official IDDSI resource. Official names and methods: https://iddsi.org/framework. Facility words such as chopped, ground, nectar, or honey are not automatic IDDSI equivalents.

FOOD PLAN (CHECK ONE)

- ☐ NPO — no food by mouth
- ☐ Level 3 Liquidised
- ☐ Level 4 Pureed
- ☐ Level 5 Minced & Moist
- ☐ Level 6 Soft & Bite-Sized
- ☐ Level 7 Easy to Chew
- ☐ Level 7 Regular
- ☐ Other / facility name: _____

Food notes (allergies, special items, or limits)

DRINK PLAN (CHECK ONE)

- ☐ NPO — no drinks by mouth
- ☐ Level 0 Thin
- ☐ Level 1 Slightly Thick
- ☐ Level 2 Mildly Thick
- ☐ Level 3 Moderately Thick
- ☐ Level 4 Extremely Thick
- ☐ Other / facility name: _____

Drink notes

SUPERVISION (CHECK ONE)

☐ Independent ☐ Setup help ☐ Intermittent supervision ☐ Close supervision ☐ One-to-one help during meals

☐ Other: _____

MEALTIME CONDITIONS

☐ Sit upright for meals, unless the care plan says otherwise.

How to give food and drink (for example, cup, spoon, or other) _____

Timing or pacing notes _____

Pills and other medicine: Do not crush or change how pills are given unless the pharmacist or doctor says it is okay.

Notes _____

Strategies per instrumental study _____

Do not change this plan on your own. Contact the SLP with questions. Follow facility or agency order procedures.

Copy to ☐ Nursing ☐ Dietary / kitchen ☐ Physician ☐ Medical record ☐ Patient / family ☐ Other: _____

Tray card completed ☐ Yes ☐ No Bedside or home sign completed ☐ Yes ☐ No

Diet-order change notice completed ☐ Yes ☐ No

SLP signature / credentials as required by the facility _____ **Date** _____ **Contact** _____

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Tray card

Print and cut. Two cards on this page, same text on each. Large, plain type. Fill in by hand or in the PDF. Typing on one card also fills the other.

Tray card

SNF SLP RESOURCES

Name _____ **Room / location** _____ **Date** _____

Food _____

Drinks _____

Supervision _____

Other instructions

Questions: call the SLP.

SLP / contact _____

Follow the current SLP plan. Do not change this plan on your own.

Tray card

SNF SLP RESOURCES

Name _____ **Room / location** _____ **Date** _____

Food _____

Drinks _____

Supervision _____

Other instructions

Questions: call the SLP.

SLP / contact _____

Follow the current SLP plan. Do not change this plan on your own.

Mealtime plan

Post at the bedside, or leave in a clear place at home.

Name _____ **Date** _____

☐ NPO — do not give food or drink by mouth unless the SLP or physician plan says otherwise.

Food _____

Drinks _____

Supervision _____

> Sit upright for meals, unless the care plan says otherwise.

Other instructions

Do not change this plan on your own. If you have questions, or if you see coughing, choking, or trouble breathing during meals, stop and get help.

SLP / contact _____

Diet-order change notice

Give a copy to nursing, dietary or the kitchen, and the medical team, and place a copy in the record, per facility or agency policy.

Patient / resident _____ **Room / location** _____ **Record #** _____

Effective ☐ Now ☐ Starting: _____

Date _____ **Time** _____

SLP _____ **Contact** _____

PREVIOUS PLAN

Food _____

Drinks _____

NEW PLAN

Food _____

Drinks _____

Supervision (if changed) _____

Reason for the change (brief)

Other notes for the team

Please update the tray, the bedside or home sign, and the diet order in the record.

Please notify ☐ Nursing ☐ Dietary / kitchen ☐ Physician ☐ Dietitian ☐ Patient / family ☐ Other: _____

Do not go back to the previous plan without a new order.

Received by (optional) _____ **Date / time** _____

SLP signature / credentials as required by the facility _____ **Date** _____

Re-evaluation and progress

Patient / resident _____ **Date of birth** _____ **Record #** _____

Date _____ **Time** _____ **Setting / room** _____ **SLP** _____

Date of last swallow evaluation or progress note _____

Current food plan _____ **Current drink plan** _____

Current supervision / mealtime conditions _____

Reason for this check ☐ Planned re-evaluation ☐ Change in medical status ☐ Staff or family concern

☐ Progress check ☐ Other: _____

What was observed or tried today

Clinical signs today (check all that apply)

☐ None observed ☐ Cough ☐ Wet or gurgly voice ☐ Shortness of breath ☐ Oral residue ☐ Reduced intake

☐ Other: _____

Impression

☐ No change to the food or drink plan

☐ Change the food and/or drink plan (complete a new Diet and liquid recommendation and a Diet-order change notice)

☐ Defer oral intake / NPO until further assessment

☐ Refer for instrumental exam ☐ Other: _____

Why (brief) _____

Updated plan or next steps

Staff or family education today ☐ No ☐ Yes — who and what: _____

Next check by _____

☐ Skilled swallow services to continue ☐ Begin discharge planning for swallow services ☐ Other: _____

This form is designed to support skilled documentation. It does not guarantee payment, coverage, or compliance with any payer.

SLP signature / credentials as required by the facility _____ **Date** _____

Discharge recommendations

Patient / resident _____ **Date of birth** _____ **Record #** _____

Date _____ **SLP** _____

Discharge to

☐ Home ☐ Home with home health ☐ Assisted living ☐ Another SNF or rehab setting ☐ Outpatient follow-up only

☐ Other: _____

Food plan at discharge _____

Drink plan at discharge _____

Supervision / who helps at meals _____

Other instructions for the next setting _____

Education provided to

☐ Patient ☐ Family / caregiver ☐ Facility staff ☐ Home-health team ☐ Other: _____

Topics reviewed (for example, the food and drink plan, signs of trouble, when to call for help)

Written materials given ☐ No ☐ Yes — what: _____

Follow-up recommended

☐ Home-health SLP ☐ Outpatient SLP ☐ Return to the current SLP if status changes ☐ Physician follow-up

☐ Instrumental exam if not yet completed ☐ No swallow follow-up at this time ☐ Other: _____

Suggested timing _____

Ask for a new swallow check if there is new or worse coughing or choking during meals, a new lung infection, unexplained weight loss, or a change in alertness during eating or drinking. For an emergency, including choking with inability to breathe, cough, or speak, call 911.

This form is not a complete discharge summary. Follow facility or agency discharge procedures.

SLP signature / credentials as required by the facility _____ **Date** _____ **Contact** _____

Instrumental swallow exam referral and rationale

This is a referral form. It is not an MBS/VFSS or FEES report.

Patient / resident _____ **Date of birth** _____ **Record #** _____

Date _____ **Setting / room** _____ **SLP** _____ **Contact** _____

Ordering provider (if required) _____

EXAM REQUESTED (CHECK ONE)

☐ MBS / VFSS ☐ FEES ☐ Either, based on facility or physician preference ☐ Other: _____

WHY THIS EXAM IS REQUESTED (CHECK ALL THAT APPLY)

☐ Cough, wet or gurgly voice, or other signs during intake
☐ Recurrent pneumonia or respiratory concerns
☐ Weight loss or poor intake related to swallowing
☐ Findings on the clinical swallow evaluation are not enough to set a safe plan
☐ A possible change in the food or drink plan would be better informed by this exam
☐ Other: _____

CLINICAL QUESTIONS FOR THE EXAM (CHECK ALL THAT APPLY)

☐ Assess swallow safety and efficiency with food and liquids
☐ Help determine the least restrictive safe food and drink plan
☐ Assess signs that may not be clear at the bedside
☐ Assess the esophageal phase (if MBS / VFSS is chosen)
☐ Other clinical questions: _____

RELEVANT BACKGROUND

Relevant history _____

Date of most recent clinical swallow evaluation _____

Brief bedside findings

Current food plan _____ **Current drink plan** _____ ☐ NPO at this time

Practical information for the exam team (oxygen, isolation, communication needs, dentures, medical limits on positioning)

Order placed in the record, if required ☐ Yes ☐ No ☐ Pending

Patient / decision-maker aware of the referral ☐ Yes ☐ No ☐ Pending

SLP signature / credentials as required by the facility _____ **Date** _____

Skilled documentation tips

This page is designed to support skilled documentation. It is not a billing guide and it does not guarantee payment, coverage, or compliance with Medicare or any other payer. Payer rules change and vary by setting. Follow current facility or agency policy, payer guidance, and your clinical judgment.

WHAT TO SHOW IN A NOTE

Write what you assessed, what you found, why your skill as an SLP was needed, what you changed, and what happens next. Tie the day's work to a functional swallow goal (see the starter goal bank).

Useful elements, when they are true for that visit:

- The skilled assessment you completed (for example, a clinical swallow evaluation, a meal observation, or a re-check of the current food and drink plan)
- Specific findings, not only "ate well"
- Why the service required an SLP, not only routine feeding help
- Education you provided, and how you checked understanding (for example, return demonstration or teach-back)
- A change to the plan, or a clear reason the current plan should stay the same
- The next step and the skilled need that remains, if services continue

SKILLED VS. UNSKILLED WORDING (EXAMPLES)

These are examples only. They are not required phrases.

LESS SKILLED (AVOID AS THE WHOLE NOTE)

"Resident ate lunch with no problems."

> **MORE SKILLED**
> "Observed lunch with the current food and drink plan. No cough or wet voice on Level 5 Minced & Moist or Level 2 Mildly Thick by cup. Intake was about half the meal; the patient stopped early because of fatigue. Educated nursing on the current plan and on stopping the meal and contacting the SLP if coughing or a wet voice appears. Skilled re-check planned by [date] to assess whether the plan still fits."

LESS SKILLED

"Worked on swallowing at bedside."

> **MORE SKILLED**
> "Completed a clinical swallow re-evaluation after a change in alertness. The patient was alert enough for trials of Level 4 Pureed and Level 1 Slightly Thick by spoon. Immediate cough was noted on a thin-liquid trial by cup, so thin liquids were not recommended. Updated the Diet and liquid recommendation and sent a diet-order change notice to nursing and dietary."

Do not copy these examples into a record if they are not true for that person.

Skilled documentation tips, continued

NOTES BY SETTING

These are general reminders, not rules.

- **SNF Part A (skilled stay):** Show why swallow services are skilled and medically necessary during the stay, what changed (or why the plan is unchanged), and how the day's work relates to the plan of care and to discharge needs.
- **SNF Part B:** Show medical necessity and skilled SLP service for that visit, progress toward measurable goals (or a clear reason progress is limited), and why services should continue or end.
- **Home health:** Show the skilled service provided in the home and why it was needed. Document education to the patient and caregiver. Follow the agency's plan-of-care and visit-documentation procedures. This page does not address homebound status or other agency eligibility questions.

If you are unsure what a payer or facility expects, ask your supervisor or health-information team, and check current written guidance. Do not rely on this pack as a regulation summary.

MEASURABLE GOAL STEMS

Edit every stem so it matches the person, the setting, and a realistic time frame. Do not write a goal that names a person-specific technique from an instrumental study. Examples of measurable parts to include:

- The person or action (patient, staff, or caregiver)
- The specific food plan, drink plan, or education target
- The condition (for example, during meals, with the current supervision level)
- How you will measure it (for example, in X of Y observed meals, or on X of Y opportunities)
- By when

See page 14 for starter examples. Rewrite them before you use them.

Starter goal bank

Examples only. Designed to support skilled documentation. Rewrite each goal so it matches the person, the setting, and your clinical judgment. These examples do not guarantee payment, coverage, or compliance with any payer.

Do not add goals that name a technique from an instrumental study, and do not add compensatory-strategy goals.

FOOD AND DRINK PLAN

The patient will tolerate [official food level] at meals with no cough, wet voice, or distress in __ of __ observed meals by [date], as documented by the SLP.

The patient will tolerate [official drink level] by [cup / spoon / other] with no cough, wet voice, or distress in __ of __ observed trials by [date], as documented by the SLP.

The patient will maintain the recommended food and drink plan, with the stated supervision, during __ of __ observed meals by [date].

INTAKE

The patient will complete at least __% of the served meal at the recommended food and drink levels in __ of __ observed meals by [date], with intake recorded by staff or the SLP.

The patient will drink at least __ ounces of the recommended liquid at __ of __ observed meals or snacks by [date], unless the physician or dietitian plan says otherwise.

ORAL CARE

The patient (or caregiver) will complete oral care before and/or after meals on __ of __ observed opportunities by [date], with a method the SLP has reviewed as safe for that person.

EDUCATION

Nursing staff or the caregiver will set up the recommended food and drink plan correctly on __ of __ observed meals by [date], after SLP education and a return demonstration.

The patient or caregiver will state two signs of swallow trouble and the next action to take (stop the meal and get help) on __ of __ opportunities by [date].

The patient or caregiver will describe the current food plan and drink plan accurately on __ of __ opportunities by [date].

PARTICIPATION

The patient will remain alert enough to participate in meals at the recommended plan for at least __ minutes in __ of __ observed meals by [date].

Longer-term (rewrite the time frame): The patient will eat and drink at the least restrictive safe plan identified by the SLP, with the needed supervision, in everyday meals by [date].

If an instrumental exam later changes the plan, update the goals to match the new food and drink recommendations. Do not write technique names into the goal.