AGENCY NAME
RISK ASSESSMENT FOR CHOKING FOR PERSONS WHO EAT BY MOUTH

Name: __________________________ Date: _____
Person/Title Completing Assessment: _______________________________

Recent History of Aspiration or Lower Lobe Pneumonia (Past Yr.) or other relevant history
______________________________________________________________________________

Instructions: Place a check mark in all areas that apply

1) _____ Age (40+)

2) _____ Dysphagia Diagnosis (DMSS) __________________________
   None___ Mild____ Moderate___ Severe___ Profound___

3) _____ History of choking (in past 3 years)
   ____A: Hospitalization for pulmonary consequences
   ____B: Acute Care for respiratory consequences
   ____C: Procedure to clear-suction, Heimlich, finger sweep
   ____D: Cleared without assistance (prolonged coughing)
   ____E: Coughing during meals, snacks or on saliva

4) _____ Prescribed Medications
   ____Cogentin___ Risperdol___ Keppra
   ____Zyprexa___ Lipitor___ Haldol
   ____Lorazepam___ Benzodiazepine___ Hydrocodon
   ____Baclofen

5) _____ Descriptive mealtime actions
   ____ Labile (laughing/talking)
   ____ Food stealing
   ____ Mania

6) _____ Descriptive mealtime behaviors
   ____ Distractible
   ____ Lethargic

7) _____ Reduced chewing ability

8) _____ Rate and Size
   ____ Rapid spooning ___ Stuffing of Solids
   ____ Rapid drinking ___ Chugging Liquids

9) _____ Poor Positioning
   ____ Leans right or left ___ Chin not parallel to thighs
   ____ Slumps forward ___ Slides down in chair

10) _____ Other
    ___ Posture 
    ___ PICA
    ___ Rapid breathing
    ___ Recurring seizures

Number of Items Checked (1-10): ________

Form should be completed by the client’s IDT (Nurse, House Manager, Case Manager, etc.) If assistance is
needed you may contact Outreach Services
Adapted by Outreach Services of IN 8-3-0 from an assessment of Robert Hochman, Director, Department of Speech and Hearing
Woodbridge Developmental Center

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