RESTORATIVE FEEDING EVALUATION

INSTRUCTIONS: After identifying the reason(s) for conducting this evaluation, give a detailed narrative for each of the areas/conditions listed below. Based upon the completed evaluation, indicate specific recommendations and formulate and record an implementation plan. If additional referrals are required prior to implementing the plan, document this under the Comments section. Record progress notes on the reverse.

REASON(S) FOR EVALUATION (Check all that apply)

❑ CVA/Stroke ❑ Alzheimer's disease ❑ Arm/Hand contractures ❑ Swallowing problems
❑ Paralysis ❑ Parkinson's disease ❑ Chewing problems ❑ Choking
❑ Arthritis ❑ Multiple sclerosis ❑ Weight loss/Poor meal intake ❑ Current tube feeder
❑ Other ____________ ❑ Other ____________

EVALUATION (Conduct at mealtime if possible. Be specific)

Mental status/Comprehension ____________
Vision/Hearing status ____________
Dental status ____________
Finger movement/Grasp ____________
Hand hold/Palm ____________ ❑ Right handed ❑ Left handed
Wrist movement ____________
Elbow movement ____________
Hand to mouth coordination ____________
Head/Neck positioning ____________
Upper extremity tremors ____________
Chewing/Swallowing ability ____________
Sucking ability ____________
Resident acceptance/Motivation ____________

RECOMMENDATIONS (Check all that apply)

ADAPTIVE DEVICES: ❑ Glass with lid/sippy cup ❑ Straw ❑ Hand wrap utensil holder
❑ Glass with lid and straw ❑ Nose cup ❑ Heavy weight utensils
❑ Double handhold on glass/cup ❑ Scoop plate ❑ Foam handle utensils
❑ Rubber matting under tray ❑ Other ____________

FOOD CONCERNS: ❑ Finger foods ❑ Serve in cup/bowl ❑ Other ____________
Texture: ❑ Pureed ❑ Ground ❑ Regular ❑ Cut meat ❑ Other ____________

ASSISTANCE REQUIRED: ❑ Tube feeding ❑ Verbal prompting/encouragement
❑ Needs tray set-up ❑ Needs to be fed by staff
❑ Other ____________ ❑ Other ____________

RESTORATIVE FEEDING PROGRAM

Implementation plan ____________
Goal ____________ Implementation date ___/___/___
Comments ____________
____
____

Evaluation date ___/___/___ Person who conducted this evaluation ____________ ___/___/___
Signature/Title *Date*

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

© SAMPLE www.BriggsHealthcare.com (800) 247-2343

 © 1992 BRIGGS, Des Moines, IA (800) 247-2343
Unauthorized copying or use violates copyright law. www.BriggsCorp.com PRINTED IN U.S.A.

RESTORATIVE FEEDING PROGRESS NOTES

All entries must be signed with name and title

DATE	PROGRESS NOTES

© SAMPLE
www.BriggsHealthcare.com
(800) 247-2343

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed