BLaST IU # 17 Feeding and Swallowing Consultation Recommendations

Name:_____ **DOB:** _____
School:_____ **DOR:**_____
Teacher/Class:_____ **CA:**_____
District:_____

Summary

Child's feeding disorder appears to present as (check all that apply)

☐ motor based ☐ sensory based ☐ structurally based ☐ experientially based

_____
_____
_____
_____

Changes in Environment:

_____
_____
_____

Postural Changes:

_____
_____

Stimulation:

sensory input (taste/ smell)_____
lip tap_____
stimulate suck_____
lingual stroke/tap _____
nuk brush_____
oral motor exercises_____
other

_____

Compensatory Support

Jaw support_____
lip support _____
other

_____

Timing/Pacing Changes

imposed pauses

_____

attend to child's cues_____
mealtime schedule_____
other_____

Utensil Change

cup_____
spoon _____
other_____

Change in Food

presentation _____
texture _____
thickness _____
taste _____
temperature _____
other

_____

Other Evaluations (MBS, ENT consult, GI consult)

_____
_____

Other

_____
_____
_____
_____
_____
_____
_____

Participants

Teacher: _____
SAFE Team Member:_____
SAFE Team Member:_____
Other: _____
Other: _____
Date: _____