

## What is the Nutrition and Swallowing Risk - Checklist?

- The Nutrition and Swallowing Risk - Checklist identifies a person's risks regarding nutrition and swallowing. However, this checklist will not diagnose a medical condition. Therefore, Appropriately Qualified Health Professionals (AQHPs) must be consulted to assess risk, provide direction for appropriate actions to reduce risks, and support the person to help keep them safe, including advice or assessment by a dietician, speech pathologist or other specialists.
- Refer to [NDIS LWB 5520 Nutrition and Swallowing Risk Checklist - Procedure](#)

Preliminary Profile					
Name:		D.O.B		CIRTS ID:	
Details of living arrangements	<input type="checkbox"/> Shared and Supported Independent Living <input type="checkbox"/> Independent residence <input type="checkbox"/> Family Home <input type="checkbox"/> Other:				
Has the Nutrition and Swallowing Risk Checklist been completed for this person previously?			<input type="checkbox"/> No <input type="checkbox"/> Yes → provide details below		
			Date last completed:		
Weight *					
Current weight		KG	Date measured:		
If there is no information about the person's weight – provide details:					
Weight change over the past 3 months: (calculate)	↑ Kg		↓ Kg		
Weight records maintained for the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No →				
Height *					
Current height		CM	Date measured:		
*refer to the <a href="#">NDIS LWB 5528 Measuring Height and Weight - Procedure</a> for instructions on how to measure the height and weight of a person. Request GP to measure and calculate BMI if required.					
If there is no information about height, please explain and provide details why below:					

<b>Note Children and young people under the age of 18</b> - should have their growth rate assessed by a GP, paediatrician, early childhood nurse or dietician every year.	Did this occur? Yes <input type="checkbox"/> No <input type="checkbox"/>
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Calculating the person's BMI				
GP will determine and calculate a person's BMI. Enter the person's weight in Kg and height in CM into the calculator: <a href="https://www.mydr.com.au/tools/bmi-calculator">https://www.mydr.com.au/tools/bmi-calculator</a>	Person's BMI:			
	<input type="checkbox"/>	Underweight	<input type="checkbox"/>	Overweight
	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Obese

**Note:** Measuring the BMI identifies changes to the person's health status, including any deterioration of existing conditions. The ideal BMI may not be relevant to the person due to their health condition or cultural background. A GP will determine BMI and can tell if the person's body mass is within a healthy range.

The person conducting the checklist			
Date checklist completed:		Person completing the checklist:	
Relationship to the person we support:	<input type="checkbox"/> DSL	<input type="checkbox"/> DSW	<input type="checkbox"/> Nurse
	<input type="checkbox"/> Parent	<input type="checkbox"/> Other - describe:	
How long has the person completing the checklist known this person?	<input type="checkbox"/> less than 6 months	<input type="checkbox"/> 6 –12 months	<input type="checkbox"/> 1 – 2 years
	<input type="checkbox"/> 3 – 5 years	<input type="checkbox"/> more than 5 years	
Where is the checklist being completed?	<input type="checkbox"/> person's home	<input type="checkbox"/> person's work	<input type="checkbox"/> person's work
	<input type="checkbox"/> Other:		
Who is the person providing the information to assist with completion?	<input type="checkbox"/> Self	<input type="checkbox"/> relative	<input type="checkbox"/> co-worker
	<input type="checkbox"/> parent	<input type="checkbox"/> close friend	<input type="checkbox"/> Other:

**Part 2 Nutrition and Swallowing Checklist**

- Provide an answer to every question.
- Refer to the explanations below each question to determine the answer. Answers are provided beside the question numbers to assist with summarising the results.
- Every question answered with ✓ Yes or ✓ Unsure needs to be transferred to Part 3 Summary of Results for review with the person's GP – **within 7 days of completing this checklist.**

**Question 1**

If the person is a child (under 18), have they lost or failed to gain weight over the last 3 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
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**Question 2**

<p>Is the person underweight?</p> <p>Tick <b>Yes</b> if either of the following is true:</p> <p><input type="checkbox"/> they are an adult, and their weight range on the BMI Index Chart is in the underweight range</p> <p><input type="checkbox"/> when you look carefully at the person (adult or child), their bone structure is easily defined under their skin. This can indicate a significant loss of fat tissue and is easily checked by looking around the eyes and cheeks. Other areas to check include the shoulders, ribs and hips.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
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**Question 3**

<p>Has the person had unplanned weight loss, or have they lost too much weight?</p> <p>Tick <b>Yes</b> if <u>any</u> of the following:</p> <p><input type="checkbox"/> the person's weight loss is undesirable or has been unexpected</p> <p><input type="checkbox"/> the person is under 18 years, and there is weight loss in two or more consecutive months</p> <p><input type="checkbox"/> the person has lost weight in two or more consecutive months and is not on a monitored weight loss program.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
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**Question 4**

<p>Is the person overweight?</p> <p>Tick <b>Yes</b> if <u>either</u> of the following:</p> <p><input type="checkbox"/> they are an adult (over 18 years), and their weight on the BMI chart is in the overweight or obese range.</p>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
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<input type="checkbox"/> they (adult or child) appear to have rolls of body fat, for example, around the abdomen.  <b>Recommended action in Summary of Results:</b> Discuss the completed <a href="#">NDIS LWB 5594 Physical Activity - Assessment</a> , and complete a Physical Activity plan with the GP			
<b>Question 5</b>			
Has the person had unplanned weight gain, or have they gained too much weight?  Tick <b>Yes</b> if <u>either</u> of the following: <input type="checkbox"/> The person's weight gain is undesirable or has been unexpected <input type="checkbox"/> The person is not on a weight gain program, and their clothes no longer fit.	Yes  <input type="checkbox"/>	No  <input type="checkbox"/>	Unsure  <input type="checkbox"/>
<b>Question 6</b>			
Is the person receiving tube feeds?  Tick <b>Yes</b> if the person is receiving <input type="checkbox"/> nasogastric, <input type="checkbox"/> naso-duodenal or <input type="checkbox"/> gastrostomy feeding (PEG).	Yes  <input type="checkbox"/>	No  <input type="checkbox"/>	Unsure  <input type="checkbox"/>
<b>Question 6a</b>			
If you answered <b>Yes</b> to question 6, does this person also receive food or drink through the mouth?  If the person does not receive food or drink through the mouth (they are 'nil by mouth'), answer questions 10,13,14,16,18,19, 25 and 27.	Yes  <input type="checkbox"/>	No  <input type="checkbox"/>	Unsure  <input type="checkbox"/>
<b>Question 7</b>			
Is the person physically dependent on others to eat or drink?  Tick <b>Yes</b> if: <input type="checkbox"/> The person cannot put food or drink into their mouth, and someone else is needed to feed them. <input type="checkbox"/> The person is dependent on assistance during a meal, e.g. guidance with utensils.	Yes  <input type="checkbox"/>	No  <input type="checkbox"/>	Unsure  <input type="checkbox"/>

Question 8			
<p>Has the person had a reduction in appetite or food or fluid intake?</p> <p>Tick <b>Yes</b> if <u>either</u> of the following:</p> <p><input type="checkbox"/> The person is not eating or drinking as much as they usually do, and this is unintentional</p> <p><input type="checkbox"/> The person appears unwilling to take most food offered to them and the equivalent of 6 large glasses of fluid each day.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>	<p>Unsure</p> <p><input type="checkbox"/></p>
Question 9			
<p>Does the person follow, or are they supposed to follow, a special diet?</p> <p>Tick <b>Yes</b> if they are on, or are supposed to be on, any of the following dietary plans:</p> <p><input type="checkbox"/> modified texture</p> <p><input type="checkbox"/> thickened fluids</p> <p><input type="checkbox"/> weight reduction or weight-increasing</p> <p><input type="checkbox"/> low fat</p> <p><input type="checkbox"/> vegetarian</p> <p><input type="checkbox"/> low cholesterol or cholesterol-lowering</p> <p><input type="checkbox"/> diabetic</p> <p><input type="checkbox"/> any other diet which modifies or restricts foods or food choices.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>	<p>Unsure</p> <p><input type="checkbox"/></p>
Question 10			
<p>Does the person take multiple medications?</p> <p>Tick <b>Yes</b> if they are usually on more than one type of medication.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>	<p>Unsure</p> <p><input type="checkbox"/></p>
Question 11			
<p>Does the person have any behaviour of concern around eating and drinking that puts them at risk?</p> <p>Tick <b>Yes</b> if:</p> <p><input type="checkbox"/> the person over-consumes alcohol or coffee, tea and cola drinks</p> <p><input type="checkbox"/> the person eats non-food items such as dirt, grass or faeces</p> <p><input type="checkbox"/> the person drinks excessive amounts of fluid</p> <p><input type="checkbox"/> the person takes or hides food and drink</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>	<p>Unsure</p> <p><input type="checkbox"/></p>

Question 12			
<p>Does the person usually exclude foods from any food group?</p> <p>Tick <b>Yes</b> if the person usually excludes <u>all foods</u> from one or more of the following groups of food:</p> <p><input type="checkbox"/> bread, cereals, rice, pasta, noodles</p> <p><input type="checkbox"/> vegetables, legumes</p> <p><input type="checkbox"/> fruit</p> <p><input type="checkbox"/> milk, yoghurt, cheese</p> <p><input type="checkbox"/> meat, fish, poultry, eggs, nuts, legumes.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>	<p>Unsure</p> <p><input type="checkbox"/></p>
Question 13			
<p>Does the person get constipated?</p> <p>Tick <b>Yes</b> if <u>either</u> of the following:</p> <p><input type="checkbox"/> their bowel movements are irregular, painful and sometimes infrequent</p> <p><input type="checkbox"/> laxatives, suppositories or enemas are required to maintain regular bowel movements.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>	<p>Unsure</p> <p><input type="checkbox"/></p>
Question 14			
<p>Does the person have frequent fluid-type bowel movements?</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>	<p>Unsure</p> <p><input type="checkbox"/></p>
Question 15			
<p>Does the person have mouth or teeth problems that affect their eating?</p> <p>Tick <b>Yes</b> <u>any</u> of the following:</p> <p><input type="checkbox"/> teeth are loose, broken or missing</p> <p><input type="checkbox"/> the lips, tongue, throat, or gums are red and inflamed or ulcerated</p> <p><input type="checkbox"/> the person has a malocclusion (upper and lower teeth do not meet), affecting their ability to chew.</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>	<p>Unsure</p> <p><input type="checkbox"/></p>
Question 16			
<p>Does the person suffer from frequent chest infections, pneumonia, asthma or wheezing?</p> <p>Tick <b>Yes</b> if <u>any</u> of the following:</p> <p><input type="checkbox"/> the person has had frequent chest infections or pneumonia</p>	<p>Yes</p> <p><input type="checkbox"/></p>	<p>No</p> <p><input type="checkbox"/></p>	<p>Unsure</p> <p><input type="checkbox"/></p>

<input type="checkbox"/> the person is usually 'chesty' or has difficulty clearing phlegm <input type="checkbox"/> the person has asthma or wheezes.			
<b>Question 17</b>			
<p>Does the person cough, gag, and choke or breathe noisily during or after eating, drinking or taking medication?</p> <p>Tick <b>Yes</b> if any of the following:</p> <input type="checkbox"/> the person will sometimes cough or choke during or several minutes after eating, drinking or taking medication <input type="checkbox"/> the person's breathing becomes noisy after eating or drinking or while taking medication <input type="checkbox"/> the person gags on eating, drinking or taking medication.	<p>Yes</p> <input type="checkbox"/>	<p>No</p> <input type="checkbox"/>	<p>Unsure</p> <input type="checkbox"/>
<b>Question 18</b>			
<p>Does the person vomit or regurgitate regularly? (Note: this question does not apply to infants under 12 months of age).</p> <p>Tick <b>Yes</b> if any of the following:</p> <input type="checkbox"/> the person vomits or regurgitates (i.e. bring up) food, drink or medication more than once per day or regularly <input type="checkbox"/> the person takes anti-reflux medication <input type="checkbox"/> the person clears their throat often or burps often.	<p>Yes</p> <input type="checkbox"/>	<p>No</p> <input type="checkbox"/>	<p>Unsure</p> <input type="checkbox"/>
<b>Question 19</b>			
<p>Does the person drool or dribble saliva when resting, eating, or drinking?</p> <p>Tick <b>Yes</b> if either of the following:</p> <input type="checkbox"/> the person drools or dribbles saliva at rest or mealtimes <input type="checkbox"/> the person's clothes or protective napkins/bibs frequently need changing due to drooling.	<p>Yes</p> <input type="checkbox"/>	<p>No</p> <input type="checkbox"/>	<p>Unsure</p> <input type="checkbox"/>
<b>Question 20</b>			
<p>Does food or drink fall out of the person's mouth during eating or drinking? (Note: this question does not relate to the person's manual dexterity or ability to place food in their mouth.)</p> <p>Tick <b>Yes</b> if any of the following:</p> <input type="checkbox"/> the person is unable to close their mouth, and this causes food, drink or medication to fall out of their mouth	<p>Yes</p> <input type="checkbox"/>	<p>No</p> <input type="checkbox"/>	<p>Unsure</p> <input type="checkbox"/>

<input type="checkbox"/> the person cannot keep their head upright, and food, drink, or medication falls out of their mouth <input type="checkbox"/> the person's tongue pushes food, drink, or medication out of their mouth <input type="checkbox"/> the person requires constant wiping or to wear a cloth to protect their clothes during mealtime.			
<b>Question 21</b>			
<p>If the person eats independently, do they overfill their mouth or try to eat very quickly?</p> <p>Tick <b>Yes</b> if they eat independently and any of the following:</p> <input type="checkbox"/> the person tries to cram or "stuff" their mouth before attempting to chew or swallow <input type="checkbox"/> the person tries to swallow too much food before they have chewed it properly <input type="checkbox"/> the person usually finishes all of their main meal in less than five minutes.	<p>Yes</p> <input type="checkbox"/>	<p>No</p> <input type="checkbox"/>	<p>Unsure</p> <input type="checkbox"/>
<b>Question 22</b>			
<p>Does the person appear to eat without chewing? (Note: this question does not apply to those on a puree diet).</p> <p>Tick <b>Yes</b> if any of the following:</p> <input type="checkbox"/> the person sucks their food instead of chewing <input type="checkbox"/> food remains in the person's mouth for a long period of time before swallowing <input type="checkbox"/> the person swallows their food whole without chewing.	<p>Yes</p> <input type="checkbox"/>	<p>No</p> <input type="checkbox"/>	<p>Unsure</p> <input type="checkbox"/>
<b>Question 23</b>			
<p>Does the person take a long time to eat their meals?</p> <p>Tick <b>Yes</b> if any of the following:</p> <input type="checkbox"/> the person eats independently, and they take more than 30 minutes to eat meals <input type="checkbox"/> the person is dependent on someone to feed them, and it takes a long time to feed the person a whole meal <input type="checkbox"/> the person appears to tire as the meal progresses and may not finish their meal.	<p>Yes</p> <input type="checkbox"/>	<p>No</p> <input type="checkbox"/>	<p>Unsure</p> <input type="checkbox"/>



Question 24			
Does the person show distress during or after eating or drinking?  Tick <b>Yes</b> if any of the following: <input type="checkbox"/> the person appears distressed while they eat or drink <input type="checkbox"/> the person appears distressed immediately after or shortly after eating or drinking <input type="checkbox"/> sometimes, while distressed, the person refuses food or spits out their food	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Question 25			
Does the person have any complex wounds, pressure sores or ulcers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Question 26			
Does the person try to access foods or fluids they may choke on?  Tick <b>Yes</b> if they do any of the following: <input type="checkbox"/> take food from other people's plates <input type="checkbox"/> take drinks prepared for other people <input type="checkbox"/> take food during food preparation <input type="checkbox"/> take food or drinks from other people's bags or lunch boxes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>
Question 27			
Does the person have Type 1 or Type 2 Diabetes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unsure <input type="checkbox"/>

**Completed by:**

<b>LWB Staff Name:</b>		<b>Signature</b>		<b>Date</b>	
<b>The person we support:</b>		<b>Signature</b>		<b>Date</b>	
<b>Authorised Decision Maker/Other:</b>		<b>Signature</b>		<b>Date</b>	

### Part 3 Summary of Results

**Yes** or **Unsure** responses recorded in the Risk Checklist indicate the person may be at risk of poor nutrition or unsafe swallowing.

The results must be discussed with the GP during the Annual Health review appointment or where the checklist has been re-completed.

Describe how the risk affects the person we support including if it is already managed well via a Mealtime Management Plan, Positioning Plan or Behaviour Support Plan etc. Follow up actions must be recorded by the GP in the Action Decided column.

<b>Summary of results for:</b>		<b>Date:</b>		<b>No risk</b> was identified for the client, GP review is <u>not required</u> .	<input type="checkbox"/>
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Question Number	Nutrition and Swallowing Risks Identified	Describe how this risk affects the person we support	Action Decided – <i>this column must be completed by the GP/Health Professional</i>

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GP Name:		GP Signature:		Date:	

**Upload to CIRTS as follows:**

Plans & Assessments > New Assessment > Service Type = the service providing the support > Assessment name – [select from drop down]  
 Nutrition and Swallowing Risk Checklist > relevant dates > Add New Attachment > SURNAME, First Name. YYYY.MM.DD