Appendix 2: Useful tools to support implementation

Dysphagia screening audit tool

Patient's name:..... UR: .....

Date of ED presentation: ..... / ..... / ..... Time of ED presentation: ..... : .....

Dysphagia screen completed Y N

Date: ..... / ..... / ..... Time: ..... : ..... Person completing screen: .....

Speech pathology swallow assessment Y N

Date: ..... / ..... / ..... Time: .... : .....

Which assessment/screen occurred first prior to oral intake:

Speech pathology ASSIST Nil

If oral intake prior to assessment, what type of oral intake:

Fluid Food Medications

Speech pathology assessment (communication assessment) Y N

Comments

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