LONG TERM CARE RD

Meal Observation Screen

Date
Resident Name
Meal
Diet/Diet Texture

Question	Circle One
1. Resident able to hold utensils independently	Y N
2. Able to coordinate food from hand to mouth	Y N
3. Able to use both hands	Y N
4. Able to finish meal without fatigue/falling asleep	Y N
5. Food spills out of mouth during meal	Y N
6. Sensory aids (glasses, hearing aids, dentures) present	Y N
7. Pain during meal evident	Y N
8. Able to use items for meal appropriately during meals	Y N
9. Able to locate items on the table appropriately	Y N
10. Able to self feed without cueing	Y N

11. Evidence of sensory impairment (vision, hearing, touch)	Y	N
12. Able to maintain head, trunk and hips positioning during meal	Y	N
13. Issues related to table height present	Y	N
14. Able to manage the meal independently (Cup, utensils, reach for items, etc)	Y	N
15. Physical/Cognitive function able to independently manage meal	Y	N
Other Comments/Observations:		