Sample Individual Choking Prevention Plan

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MIS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pica: YES / NO

Plan Rationale:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Mealtime Support Needs:

**Prescribed Diet Texture:** [ ] Regular [ ] Chopped ½” [ ]  Ground ¼” [ ]  Puree

 [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescribed Liquid Consistency**: [ ] Thin/Regular [ ] Nectar Thick [ ] Honey Thick [ ] Pudding Thick [ ] Other:

**Adaptive Equipment:**

**Positioning:**

**Mealtime Behaviors**:

**Mealtime Supervision:**

**Safe Eating Strategies:**

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*
*
*

**Adaptive Equipment Photos:**

**Positioning Photos**:

# Recent Medical Visits:

**Primary Physician: Gastroenterologist (GI):**

**Ear/Nose/Throat (ENT): Swallow Study:**

# Form Reviewed By:

Name: Signature: Date:

Name: Signature: Date: