New Mexico - DDSD
Nursing - Collaborative Aspiration Risk Assessment Tool

Individual: **last 4 digits of SS#:** **Residential/Day Agency**:

Date of Assessment **Time :** Loc**ation**: ☐ home ☐ day ☐ work ☐ other _____ **Last Aspiration Risk Screen Date:** **Results:** ☐ **Moderate** ☐ **High**

Agency Nurse/ (print/type): **Agency Nurse (signature)**: _____/_____(co sign)

Other team members present:

Vital Signs: T P R BP

Oxygen Use:

Pulse Oximeter reading (if available): **Usual range of pulse Oximeter results:**

Most recent weight: (date) **Weight 6 months ago (date)** **Weight Loss?** ☐ **no** ☐ **yes** **Comments:**

Tube Feedings (if applicable, comment on status or any issues with tube feedings):

If intake observed by nurse, note type: breakfast ☐ **lunch** ☐ **dinner** ☐ **snack** ☐ **oral fluids** ☐ **tube feeding** ☐

Document O= Observed by nurse R= Reported by Staff

Observation Checklist:	**Always**		**Usually**		**Occasionally**		**Rarely**		**Never**	
1. Does the individual's voice/vocalizations sound gurgly, wet, or weak?										
2. Does the individual's voice or vocalizations change during or after a meal or tube feeding?										
3. Does individual require suctioning?										
4. Does the individual cough routinely?										
5. Does individual cough, choke, clear throat or gag during or after eating, drinking or tube feeding?										
6. Does the individual gag, cough or choke 1-2 hours after eating/tube feeding?										
7. Does individual lose food/formula from their mouth/nose during eating/tube fdg?										
8. Does individual have food left over in the mouth after a meal?										
9. Is there noticeable shortness of breath during and/or after eating/tube feeding?										
10. Is there wheezing that is not associated with asthma?										
11. Are there low-grade fevers of unknown origin?										
12. Is it difficult to maintain proper positioning during or after meals or tube feedings?										

Narrative Notes: Include additional comments on above items and other areas as needed such as appearance (color, pallor, cyanosis) vital signs (change in respiratory or heart rate); respiratory status (lung sounds; need for respiratory treatment, etc); cognitive status, (disorientation, confusion, irritability) or reported differences noted between day or residential settings. Note if episodes of pneumonia were caused by aspiration, virus or bacteria.

Final Risk Level as determined by clinical team through assessment: ☐ low ☐moderate ☐ high