ASSESSMENT OF PNEUMONIA RISK

Name: _____ Date: _____

Persons/Titles Completing Assessment:_____

Instructions: **Place a check mark in all areas that apply**

1. _____ 50 years old or older **AGE**:_____
2. _____ Hx. of one or more episodes of pneumonia in the last five years.
   Number of episodes _____ Dates: _____
3. _____Dysphagia diagnoses with pharyngeal phase symptoms
   (As documented on MBS or FEES)
4. _____Poor oral/dental status including signs of periodontal or gingival disorder, cavities or poor oral hygiene.
5. _____Dependent for oral care
6. _____Feeding modality
   a. _____Enteral feeding
   b. _____Eats by mouth and dependent for feeding for all or part of meal
7. _____Multiple medical diagnoses and/or multiple prescription medications
8. _____Requires a positioning program
9. _____Now or former smoking
10. _____Dry mouth or excess oral secretions
11. _____Diseases/conditions including GERD, esophageal dysmotility, CHF, COPD, Asthma (circle those that apply).

Number of Items Checked (1-11):_____

Form should be completed by the client's IST (Nurse, House Manager, Case Manager, etc..)

Prepared 2004 Justine Joan Sheppard, Ph.D.
Nutritional Management Associates
Outreach Services of Indiana