

STEP 1 ASSESSMENT: BETWEEN MEAL SNACK AND ORAL SUPPLEMENT CONSUMPTION

DATE ___ / ___ / ___

SNACK TIME: ___Morning ___Afternoon ___Evening

GROUP ACTIVITY: _____

RESIDENT NAME	Food Items Given	Total % Eaten	Fluid Items Given	Amount Consumed	Type of Assist*	Total Assist Time (min)	SUPPLEMENT?	
							Y/N	oz. consumed
1				OZ				OZ
2				OZ				OZ
3				OZ				OZ
4				OZ				OZ
5				OZ				OZ
6				OZ				OZ
7				OZ				OZ
8				OZ				OZ
9				OZ				OZ
10				OZ				OZ

Comments:
1
2
3
4
5
6
7
8
9
10

* Codes for Type of Assist
None = N (no assistance provided) **Physical** = P (e.g., aide feeds resident) **Physical Guidance** = PG (e.g., aide guides resident to feed self)
Verbal = V (e.g., "Pick up your spoon and take a bite"; "Swallow") **Social Stimulation** = SS (e.g., "How are you today?"; "How are you feeling?")