MedStar Georgetown University Hospital

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Pediatric Feeding and Swallowing Evaluation

Modified Barium Swallow Questionnaire

Your doctor recommended that your child have an exam called a Modified Barium Swallow Study also known as a Videofluoroscopic Swallow Study. This exam is completed in Pediatric Radiology with both a Speech-Language Pathologist and a Radiologist present. During the exam, your child will eat/drink food by mouth that you bring in from home.

This form has important questions that help the therapist understand your child and prepare for the Modified Barium Swallow study. Please fill in all areas that you can.

Completed by (Name/relationship to patient): _____Date:_____

Child's Name: _____ Date of Birth: _____ Age:_____
Address: _____
Primary language spoken at home: _____ Other languages spoken:_____
Email: _____ Secondary Email: _____
Preferred Phone Number: _____ Alternate Phone Number:_____

Why are you coming for a Modified Barium Swallow evaluation? What are your or your doctor's main concerns?

_____
_____
_____
_____

Has your child been previously evaluated or treated by an occupational therapist, physical therapist, or speech language pathologist? **Date(s) of evaluation(s)?**

_____
_____
_____
_____

Please indicate any known adverse/allergic drug and/or food allergies (e.g., penicillin, latex, gluten, milk protein):

_____
_____

Birth

❒ Full Term ❒ Premature ❒ Post mature _____ Born at weeks gestation age
❒ Vaginal birth ❒ C-section Reason: _____

Current Medical Status

Please tell us all **other doctors or specialists** involved in your child's care:

Specialty of Physician (ENT, GI, Geneticist)	Name of Physician (First and Last)	Date Last Seen	Phone Number(s)	Fax Number
Pediatrician				

Please list all **medical diagnoses** your child has:

Diagnosis	Age at time of Diagnosis	Diagnosing Physician

Please list all **medications** your child takes:

Medication	Dosage	Route (Oral, Nasal)	Frequency	Prescribing Physician	Start Date	Stop Date

Please **list any additional special tests, imaging, procedures, and/or hospitalizations/surgeries** since birth (MRI, EEG, etc.):

Date	Procedure	Reason for Testing	Results of Procedure

Feeding

How does your child currently receive nutrition? Check **all** that apply:

❒ Breast feed
❒ Bottle: Brand (e.g., Dr. Brown, Avent) _____
Nipple type (e.g., fast, level 1): _____
❒ Open Cup
❒ Straw
❒ NG-Tube
❒ G-Tube
❒ Sippy Cup
❒ Spoon/Fork
❒ Hands

If your child receives tube feedings, please complete the following:

❒ Continuous Feeds: _____ cc/hour for _____ hours
Beginning time: _____ Ending Time: _____

❒ Bolus Feeds: _____cc/oz
Times Given: _____

Which foods does your child currently take?

❒ Breast Milk
❒ Formula: _____
Calories (e.g., 28 kcal):_____
❒ Stage 1 Baby Food
❒ Stage 2 Baby Food
❒ Stage 3 Baby Food
❒ Pureed Table Foods
❒ Soft Chewables
❒ Pediasure
❒ Hard Chewables
❒ Chewy foods

List your child's preferred foods/liquids: _____
List your child's non-preferred foods/liquids: _____
How long does a meal (or for infants, a bottle) usually take (e.g., 5 minutes, 1 hour)? _____
_____

Does your child display any of the following behaviors related to feeding?

❒ Frequent coughing/choking during feeding
❒ Gagging/vomiting during feeding
❒ Refusal behaviors (e.g. head turning) related to feeding
❒ Difficulty accepting foods of certain textures
❒ Difficulty chewing
❒ Holding food in mouth
❒ Dream feeding (bottle feeding only when sleeping)

Other (please describe any difficulties related to feeding/swallowing):
_____
_____

Has your child had a Swallow Study (in Radiology) by a Speech Pathologist? ❒ Yes ❒ No

If yes: Where: _____ When: _____
Results: _____
_____

Does your child have regular bowel movements? ❒ Yes ❒ N How many per day? _____

Does your child experience constipation? ❒ Yes ❒ N

Does your child experience diarrhea? ❒ Yes ❒ N

Please fill in all areas that you can and return the form via email to:
Pedsmbs@gunet.georgetown.edu

THIS QUESTIONNAIRE WAS REVIEWED BY:

Therapist's Signature: _____ **Date: _____**