



Meal Observation Screening (MOS)

Initial Screen Re-Screen Annual Review

Instructions: <ul style="list-style-type: none"> Observe a minimum of one meal and record observations. Observation should occur with the resident's current diet order Circle one: B = Breakfast, L = Lunch, S = Supper Write down the food texture and liquid thickness Dentures/glasses/hearing aids should be worn Observe the entire meal 	OBSERVATION 1	OBSERVATION 2	OBSERVATION 3
	B L S	B L S	B L S
	Food texture:	Food texture:	Food texture:
	Liquid thickness:	Liquid thickness:	Liquid thickness:
Date:	Date:	Date:	
D D M M M Y Y Y Y	D D M M M Y Y Y Y	D D M M M Y Y Y Y	
Initials:	Initials:	Initials:	

Section I: Indicators of Swallowing Difficulties	Yes	No	Yes	No	Yes	No
1. Cough or clear the throat frequently while eating/drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Sound gurgly or wet after swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Hold food or liquid in the mouth for a long time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have difficulty chewing food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Spill or drool food/liquid from the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Complain of pain when swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have food remaining in the mouth after swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Cough frequently after a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Eat quickly/have impulsive eating behaviours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If any "YES" checked, refer to Clinical Dietitian & Speech-Language Pathology

Section II: Indicators of Feeding Difficulties	Yes	No	Yes	No	Yes	No
10. Difficulty using a utensil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Difficulty holding head upright for the whole meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Difficulty sitting upright	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If any "YES" checked, refer to Clinical Dietitian & Occupational Therapy

Comments

Referral(s) sent to:	Yes	No	Date Referred:
	<input type="checkbox"/>	<input type="checkbox"/>	D D M M M Y Y Y Y
	<input type="checkbox"/>	<input type="checkbox"/>	
Speech-Language Pathology	<input type="checkbox"/>	<input type="checkbox"/>	
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Clinical Dietitian	<input type="checkbox"/>	<input type="checkbox"/>	
Reviewed by Nursing (Print name):	Signature:		Date:
			D D M M M Y Y Y Y