Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

Meal Observation Screening (MOS)

☐ Initial Screen ☐ Re-screen ☐ Annual Review

Instructions: Observe a minimum of one meal and record observations below

Check one: B = Breakfast, L = Lunch, D = Dinner • **Make sure resident is wearing dentures, glasses and hearing aids** • **Record the liquid and food texture provided** • **Observe the resident for an entire meal** • **Please date and initial the form upon completion of observation**	**OBSERVATION 1** ☐B ☐L ☐D Diet texture: Fluids: Date: D D M M M Y Y Y Y Initials:	**OBSERVATION 2** ☐B ☐L ☐D Diet texture: Fluids: Date: D D M M M Y Y Y Y Initials:	**OBSERVATION 3** ☐B ☐L ☐D Diet texture: Fluids: Date: D D M M M Y Y Y Y Initials:

Section I: Swallowing Abilities **Does the Resident:**	Yes	No	Yes	No	Yes	No
1. Demonstrate an absent swallow reflex?	☐	☐	☐	☐	☐	☐
2. Cough or clear the throat frequently while eating/drinking?	☐	☐	☐	☐	☐	☐
3. Sound gurgly or wet after swallowing?	☐	☐	☐	☐	☐	☐
4. Hold food or liquid in the mouth for a long time before swallowing?	☐	☐	☐	☐	☐	☐
5. Have difficulty chewing food?	☐	☐	☐	☐	☐	☐
6. Spill or drool food from the mouth while eating?	☐	☐	☐	☐	☐	☐
7. Complain of pain when swallowing?	☐	☐	☐	☐	☐	☐
8. Have food remaining in the mouth after swallowing?	☐	☐	☐	☐	☐	☐
9. Cough frequently after a meal?	☐	☐	☐	☐	☐	☐
10. Demonstrate impulsive eating behaviors?	☐	☐	☐	☐	☐	☐
11. Demonstrate poor intake and weight loss?	☐	☐	☐	☐	☐	☐
12. Eat quickly or slowly? (circle as indicated)	☐	☐	☐	☐	☐	☐
13. Demonstrate resistance to feeding at mealtime?	☐	☐	☐	☐	☐	☐
Comments:						

Section II: Feeding Abilities **Does the Resident:**	Yes	No	Yes	No	Yes	No
14. Have difficulty using a utensil?	☐	☐	☐	☐	☐	☐
15. Have difficulty holding his/her head upright for the whole meal?	☐	☐	☐	☐	☐	☐
16. Have difficulty sitting upright?	☐	☐	☐	☐	☐	☐
Comments:						

Date MOS Completed: D D M M M Y Y Y Y	Completed By:	Signature:
Reviewed by Nursing:	Signature:	Date: D D M M M Y Y Y Y

Referral Required for:	Date Referred D D M M M Y Y Y Y	Date Acknowledged D D M M M Y Y Y Y	Initials	Date Complete D D M M M Y Y Y Y	Initials
☐ **Swallowing Assessment by Speech-Language Pathologist**					
☐ **Feeding Assessment by Occupational Therapist**					
☐ **Nutrition Assessment by Registered Dietitian**					