SLP-Assistant Swallowing Protocol Form

Name:_____ DOB: __/__/____ Cert. Period: __/__/__ - __/__/__ Freq.: _____

Duration:_____ Place of Service: ☐Home ☐Pt Room ☐ Dining Hall ☐ Other: _____

Safety Protocols/Procedures:

Attach any additional documentation

Goals:

Goal Short-Term/Long-Term (circle one):		
Instructions:		
Skilled Interventions/Methods: ○ _____ ○ _____ ○ _____ ○ _____ ○ _____ ○ _____ ○ _____ ○ _____	Cues/Prompts: ○ Verbal ○ Visual ○ Kinesthetic ○ Gestural ○ Model ○ _____ ○ _____ ○ _____	Levels: ○ Independent ○ Minimal ○ Mild ○ Moderate ○ Maximum Textures: ○ _____ ○ _____ ○ _____ ○ _____ Examples: regular solids, mechanical soft, puree, thickened liquids, thin liquids

**These plans shall not be for "medically fragile" patients, as they are not within an SLP-Assistant's scope.*

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Skilled Interventions/Methods:	Cues/Prompts:	Levels:
○ _____ ○ _____ ○ _____ ○ _____ ○ _____ ○ _____ ○ _____ ○ _____	○ Verbal ○ Visual ○ Kinesthetic ○ Gestural ○ Model ○ _____ ○ _____ ○ _____	○ Independent ○ Minimal ○ Mild ○ Moderate ○ Maximum Textures: ○ _____ ○ _____ ○ _____ ○ _____ Examples: regular solids, mechanical soft, puree, thickened liquids, thin liquids

I _____ (SLP supervisor), have directly observed and properly trained _____(SLP-Assistant), I certify the SLP Assistant will only be providing services within their scope as an SLP Assistant and their personal skill level.

Signatures:

Supervising SLP: _____ Date: _____

SLP-Assistant: _____ Date: _____

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