

PHYSICAL/NUTRITIONAL MANAGEMENT TEAM SUMMARY	Consumer Name: Avatar #: Living Area/Unit: Date of Birth: Date of Admission: Date of Evaluation:
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This form will be initiated anytime there is a change in the consumer's status that would have an effect on the risk for Choking, Dysphagia, Aspiration or Aspiration Pneumonia.

Date:	Problem:
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Based on observations and staff interviews, the Physical/Nutritional Management Team (PNMT) will include, but not be limited to, the following information (as appropriate):

- Signs/Symptoms *(All)*
- High Risk for Aspiration and Choking – including history *(Nursing)*
- Current Mode of Nutritional Intake (orally, tube feeding and type, thickened liquids, etc.)
- Recommendations and Rationale *(All)*

PNMT	Evaluation
Physician:	
Nurse:	
Speech Therapist:	
Occupational Therapist:	
Dietitian:	
Other (specify)_____:	

Physician's Diagnosis, Treatment and Rationale	
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Risk Level as identified by Physical and Nutritional Risk Screening Assessment:

- Minimal
 Moderate
 Severe

	Signatures	Date
Physician:		
Nurse:		
Speech Therapist:		
Occupational Therapist:		
Dietitian:		
Other (specify)_____:		