Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg

Meal Observation Screening (MOS)

☐ Initial Screen ☐ Re-Screen ☐ Annual Review

Instructions:

- 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: D D M M M Y Y Y Y	Date: D D M M M Y Y Y Y	Date: 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	☐	☐	☐	☐	☐	☐
2. Sound gurgly or wet after swallowing	☐	☐	☐	☐	☐	☐
3. Hold food or liquid in the mouth for a long time	☐	☐	☐	☐	☐	☐
4. Have difficulty chewing food	☐	☐	☐	☐	☐	☐
5. Spill or drool food/liquid from the mouth	☐	☐	☐	☐	☐	☐
6. Complain of pain when swallowing	☐	☐	☐	☐	☐	☐
7. Have food remaining in the mouth after swallowing	☐	☐	☐	☐	☐	☐
8. Cough frequently after a meal	☐	☐	☐	☐	☐	☐
9. Eat quickly/have impulsive eating behaviours	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐
11. Difficulty holding head upright for the whole meal	☐	☐	☐	☐	☐	☐
12. Difficulty sitting upright	☐	☐	☐	☐	☐	☐
If any "YES" checked, refer to Clinical Dietitian & Occupational Therapy						

Comments

Referral(s) sent to:	**Yes**	**No**	**Date Referred:** D D M M M Y Y Y Y
Speech-Language Pathology	☐	☐	
Occupational Therapy	☐	☐	
Clinical Dietitian	☐	☐	

Reviewed by Nursing (Print name):	Signature:	Date: D D M M M Y Y Y Y