



Mealtime Management Plan	
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Name of Participant:	
Participant registration number:	Date of birth:
Address:	
Phone number:	Email:
Please indicate one of the following: <input type="checkbox"/> New plan <input type="checkbox"/> Plan review	Date:

Mealtime Management Assessment	
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Has the participant been assessed by an appropriately qualified health practitioner? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insert name and profession of appropriately qualified health practitioner:	
Phone: 66622866	Email:
Insert name and profession of appropriately qualified health practitioner:	
Phone: 66622866	Email:
Insert name and profession of appropriately qualified health practitioner:	
Phone:	Email:

People preparing Mealtime Management Plan	
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Name of person preparing mealtime plan:	
Contact details:	Profession:
Name of person preparing mealtime plan:	
Contact details:	Profession:
Name of person preparing mealtime plan:	
Contact details:	Profession:



Participant details	
Does the participant require severe dysphagia management?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the participant/parent/carer been involved in the development of this plan, with their consent?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Important issues	
Please write a summary of the important issues related to the participant's mealtime needs:	
Allergies	
Precautions (list known allergies here):	
Response strategies:	
PRN Medication:	
[All PRN medication for allergies must be administered as per GP or specialist recommendations]	
Needs	
Consistency of food as per IDDSI paediatric framework: <ul style="list-style-type: none"> <input type="checkbox"/> 7 Easy to chew (tender enough to break apart with side of fork) <input type="checkbox"/> 6 Soft and bite-sized (no bigger than 8 mm) <input type="checkbox"/> 5 Minced and moist (minimal chewing, no biting required, lumps smaller than 2mm x 8mm) <input type="checkbox"/> 4 Smooth pureed (eaten with spoon, no chewing) <input type="checkbox"/> 3 Liquidised moderately thick (eaten with spoon) <input type="checkbox"/> 2 Liquidised mildly thick (taken with spoon or drunk) <input type="checkbox"/> 1 Liquidised slightly thick (flows through a straw) <input type="checkbox"/> 0 liquidised Thin (flows like water) 	Consistency of drink as per IDDSI framework: <ul style="list-style-type: none"> <input type="checkbox"/> 0 Thin (regular, flows like water) <input type="checkbox"/> 1 Slightly thick (flows through straw) <input type="checkbox"/> 2 Mildly thick (flows off a spoon, sippable) <input type="checkbox"/> 3 Moderately thick (liquidised, sippable, can be eaten with a spoon) <input type="checkbox"/> 4 Extremely thick (pureed, eaten with a spoon)



Special dietary requirements: [e.g. Weight reduction, Lactose free, Phenylketonuria etc.]	
Describe the level of monitoring the participant requires at mealtime:	
Describe the issues to look out for when monitoring the participant:	
Assistance required: [e.g. positioning, oral care etc. Include photographs where relevant.]	
Describe how the participant communicates their needs during mealtime:	
Medication to be provided with meal:	
Utensils/equipment:	
Additional comments:	
Preferences [to be completed with input from the participant]	
Likes: <ul style="list-style-type: none">•••	Dislikes: <ul style="list-style-type: none">•••
Cultural/religious preferences:	
Preferred environment: [e.g. Noise level, lighting, noise level etc.]	
Additional comments:	



Plan endorsement	
Participant name: Participant signature:	Date:
Guardian name: Guardian signature:	Date:
Profession: Name: Signature:	Date:
Profession: Name: Signature:	Date:
Profession: Name: Signature:	Date:

Monitoring and Review

Monitoring and review of corrective action will be undertaken by [\[insert name of staff member\]](#) on [\[insert date\]](#).