Clinical Audit Tool:
Ampcare Effective Swallowing Protocol

The site where treatment was completed: ______________________________

Audit ID:	**Sex:**	**Age:**	**Ethnicity:**

The audit ID should be an anonymous code. Patient-identifiable information should never be recorded.

Medical Diagnosis:

BASELINE DATA			
Reason for dysphagia (tick all that apply)	**Determined by VF/FEES**	**Bedside Assessment**	**Cranial Nerve Assessment**
Anterior loss/drooling			
Poor mastication and oral pocketing			
Reduced tongue base retraction			
Poor epiglottic retroversion			
Decreased closure of the larynx			
Weak pharyngeal constrictor contraction			
Decreased anterior superior elevation of hyolaryngeal complex			
Residue in valleculae /pyriform sinuses			
Failure of opening of UES/PES			
Timing, control, and initiation of the swallow			

Date of Onset of Dysphagia:	
Date of first intervention:	
Suitability for treatment determined by: ☐VF/FEES ☐Bedside Assessment ☐Cranial Nerve Assessment	

Consent
Has the patient given written consent to treatment? ☐ Yes ☐ No

Measures	**Pre-treatment**	**Post-treatment**	**Is this an improvement? Yes /No**
	Date:	Date:	
Swallowing-related Quality of Life (SWAL-QOL) score			☐ Yes ☐ No
MD Anderson Dysphagia Inventory (MDADI) score			☐ Yes ☐ No
Functional Oral Intake Score (FOIS)			☐ Yes ☐ No
Penetration Aspiration Scale (PAS) score			☐ Yes ☐ No
Residue rating scale Valleculae: Pyriform sinuses: Scale: 0= No residue 1=Trace residue 2=Collection of residue 3=Majority of contrast remains 4=Minimal/no clearance			☐ Yes ☐ No ☐ Yes ☐ No
Other measures (Please state):			

Procedure Information	
Technical details of procedure: Placement of electrodes: ☐ Submental ☐ Facial (☐ Right / ☐ Left / ☐ Bilateral) ☐ ESP1 ☐ ESP2 ☐ Manual ________ Highest Intensity: ______________ Rest phase: ☐ 25 sec ☐ 20 sec ☐ 15 sec Length of session: Sessions per week: Number of weeks: Number of interventions tolerated:	**Comments:**
Intervention/ exercises tolerated: (Tick all that apply) ☐ Lip strengthening ☐ Tongue strengthening ☐ Effortful swallow ☐ Chin to chest ☐ Chin to chest with jaw opening ☐ Mendelsohn ☐ Shaker ☐ Thermal stimulation ☐ Other (specify)	**Comments:**

Procedure Information Continued	
The number of therapists providing intervention:	
Was the restorative postural device used: ☐ Yes-all sessions ☐ Yes- some sessions (how many)? ☐ No- not at all	**Comments:**

Side Effects / Complications
Burning Sensation ☐ Yes ☐ No
Skin irritation ☐ Yes ☐ No
Soreness ☐ Yes ☐ No
Coughing / expectoration ☐ Yes ☐ No
Neck / jaw pain ☐ Yes ☐ No
Headache ☐ Yes ☐ No
Increasing severity of dysphagia while receiving stimulation ☐ Yes ☐ No
Other (please specify)

Patient Feedback or Comments:

Please return your completed form to:
Dr Sue Pownall spownall@ampcarellc.com

Thank you for completing the form.