

Swallowing Diary

Resident's name: _____ NHS number: _____ Date completed: _____

Time of day	Posture & location of resident	How was the resident feeling? (e.g. well, tired etc.)	Details of the food and/or drink taken	Description of difficulties experienced e.g. coughing, throat clearing, vomiting, wet voice during/after food or drink, refusal of food
Breakfast			Food:	
			Drink:	
Morning snack			Food:	
			Drink:	
Lunch			Food:	
			Drink:	
Afternoon snack			Food:	
			Drink:	
Evening meal			Food:	
			Drink:	
Evening snack			Food:	
			Drink:	