Centre de réadaptation MAB-MACKAY Rehabilitation Centre

Last Name:		
First Name:		
File No.:		
D.O.B: ____/___/___		Sex: ☐ M ☐ F

SALIVA MANAGEMENT CLINIC
PARENT QUESTIONNAIRE

The following questionnaire is designed to help us prepare for your up-coming visit at the Saliva management clinic. We ask that you complete the questionnaire to assist in evaluating your child's drooling problems.

Reason for referral:

☐ Health related (i.e. aspiration, hospitalization, etc.)

____

☐ Impact of life habits (i.e. participation in school/leisure/community activities, self-esteem, social integration, reactions from siblings/peers/family members etc.)

____

____

☐ Burden on family (i.e. parents very concerned, social isolation, changes of bibs, clothes, etc.)

____

____

History of your child's drooling problem:

- **How often does the drooling occur?**

☐ Occasionally ☐ Frequently ☐ Constantly

- **Which of the following is most typical of the drooling problem?**

☐ Moist lips
☐ Moist chin
☐ Other (specify)
☐ Wet shirt front or clothes
☐ Wet materials on tray or table in of her/him

What interventions have you tried in the past to address the drooling problems?

____

____

Is your child aware of his/her drooling problems? ☐ Yes ☐No ☐Variable

If <u>yes</u>, how does your child respond/react to his/her drooling?___________________

____

Are there any feeding or swallowing problems? If so, please describe:

____

____

3500 boul. Décarie, Montréal QC H4A 3J5
Tél : (514) 488-5552 Téléc. : (514) 482-4536 ATS/TTY (514) 482-4536
7000 rue Sherbrooke Ouest, Montréal QC H4B 1R3
Tél : (514) 488-5552 Téléc. : (514) 489-3477

Last Name:	
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Child's diet: ☐ Regular ☐ Liquid ☐ Pureed ☐ Chopped

Are there ant respiratory/breathing problems? If so, please describe:

____

____

If medication or devices are recommended following the team assessment are not covered by RAMQ, do you have any private insurances? ☐ Yes ☐No

If your child is currently followed by an occupational therapist or speech and language pathologist, would you like the treating therapist to be present at the appointment on the clinic day?
☐ Yes ☐No Name of the therapist:______________________________
Profession/Rehabilitation Centre:______________________

Signature:__________________________________
Relationship to client:__________________________ **Date:**__________________

Please note: Feeding will be observed as part of the saliva management assessment. Please bring any special food and/or eating/drinking utensils (e.g. special spoon, cup) to the clinic appointment.

This document must be returned as soon as possible to:

Saliva Management Clinic
c/o Clinic Secretary
MAB-Mackay Rehabilitation Center
3500, boul. Décarie
Montréal (Québec) H4A 3J5
Fax : (514) 482-4536

If you have any questions, please call the clinic secretary at 514-488-5552 ext. 2102.