

Comprehensive Aspiration Risk Management Plan (CARMP)

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CARMP: Initial Annual Date: Click or tap to enter a date. Revised: Y Revision Date: Click or tap to enter a date. Risk level: Click or tap here to enter text.

Date of ARST: Click or tap to enter a date. ISP Term: Click or tap here to enter text. Case Manager: Click or tap here to enter text. CM Agency: Click or tap here to enter text.

NOTE: Some CARMP Strategies may be optional for persons at moderate risk for aspiration due to Risky Eating Behavior (REB), when that is the ONLY criteria met on the Aspiration Risk Screening Tool (ARST). The optional REB strategy sections are labeled as “**Optional for REB Only”. Other required CARMP sections continue to be required or may be determined “not applicable (n/a)” based on assessment & IDT consensus.

REB ONLY criteria DCF signed Date: All sections deferred in setting OR Note changes in each section below

STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
A. RECOGNIZE AND REPORT INDIVIDUAL SPECIFIC SIGNS AND SYMPTOMS OF ASPIRATION (required)		
<p>The following is a list of those specific signs and/or symptoms (S&S) of aspiration or aspiration associated illnesses (including dehydration) that have been identified for this person. This should not be a generic listing of S&S of aspiration that applies to all people. <i>(If specific S&S are not known the IDT may use generic until individual specific S&S identified)</i></p> <ol style="list-style-type: none"> 1. 2. 3. 4. <p>EMERGENCY response information(as needed)</p> <ol style="list-style-type: none"> 1. 2. 		<p>Nurse All IDT members should:</p> <ul style="list-style-type: none"> • Provide input • Monitor and report
<p>All IDT members are required to monitor for individual specific signs and symptoms of aspiration When any of the identified signs and/or symptoms listed above is observed the following actions are required:</p> <ol style="list-style-type: none"> 1. <u>The observer</u> calls the agency nurse to report the observation & make a note in the daily documentation at that site. 2. <u>The nurse</u> determines the appropriate follow up action, coordinates this with the direct support personnel (DSP) and documents in nursing notes. Nursing actions may include, but are not limited to, contacting the PCP, monitoring temperature, O2SAT, pulse, and respirations for next 72 hours, sending the person to urgent care or the emergency room. 3. <u>The nurse</u> informs the <u>observer</u> of the actions taken and follow up as needed. 4. <u>DSP</u> will document all actions taken. 		<p>Nurse</p> <ul style="list-style-type: none"> • All IDT members are responsible to monitor, report, and implement strategies
B. HEALTH MONITORING AND REPORTING (required)		
Observe and report to the nurse immediately: choking that requires suctioning, abdominal thrusts or 911 response.		Nurse
Use Pulse Oximeter: (frequency) Notify Nursing: (insert range)		Nurse
If vomiting or seizures occur: Follow the HCP.		Nurse
1. Identify positioning during vomiting: Identify positioning during seizures: (Refer to Seizure Plan)		

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2. Call the nurse. 3. If vomiting occurred; check temperature, pulse, respirations, and O2 saturation level (pulse oximeter) three times a day, for three days. Document all results in Therap and notifies nurse of each result. 4. If any S&S of aspiration or aspiration associated illness are present after vomiting, immediately have the person seen by the PCP, urgent care, or in the ER.		
Nurse will monitor and document clinical and respiratory status and report to PCP as needed.		Nurse
Staff will monitor weight (frequency): Nurse to notify PCP for weight loss/gain of 10 lbs. or 10% bodyweight within 6-month period.		Nurse
All IDT members are required to monitor for signs and symptoms of dehydration as listed in section A (some examples are dry mouth, poor skin turgor, low or dark urine output, etc.). Notify nurse and RD with concerns.		Nurse
Other Monitoring & Reporting Related to: 1. Respiratory/bronchial issues. Refer to respiratory care plan if needed. <input type="checkbox"/> Yes <input type="checkbox"/> N/A 2. Other: GERD, constipation, seizures, etc. Refer to other plans as needed. <input type="checkbox"/> Yes <input type="checkbox"/> N/A 3. Hydration/Dehydration due to other complex medical/behavioral needs. Refer to plan as needed. <input type="checkbox"/> Yes <input type="checkbox"/> N/A		Nurse
C. ORAL INTAKE STRATEGIES (required if the person eats, drinks, or takes medications orally) <input type="checkbox"/> Not applicable - 100% NPO (if checked, delete all areas in section below)		
Positioning of person when eating or drinking anything (home, community, vehicle, other):		PT, OT
Positioning of person assisting with all food or fluids (indicate N/A if person feeds themself by bringing the food to their own mouth; put supervision instructions in Supervision section below):		PT, OT
Nutrition Recommendations: <input type="checkbox"/> Refer to more detailed Nutrition Plan, as needed. 1. Nutrition goals: 2. Recommended weight range: 3. Diet order: 4. Food allergies, if known: 5. Supplements/snacks (do not list vitamins): 6. Caloric needs per 24 hours (For informational purposes; does not need to be tracked unless stated): 7. Protein needs per 24 hours (For informational purposes; does not need to be tracked unless stated): 8. Fluids: a. Fluid intake needs per 24 hours (For informational purposes; does not need to be tracked unless stated): b. Fluid intake restrictions (per PCP orders): Ordered I&O must be tracked.		RD

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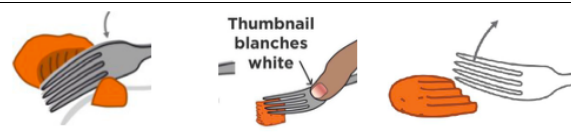
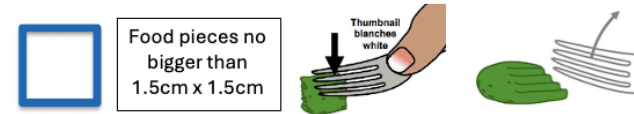
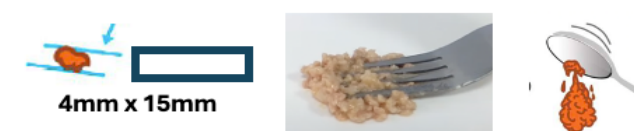
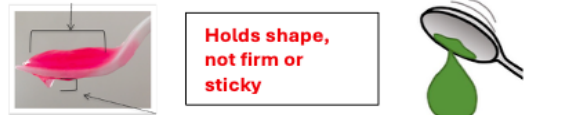
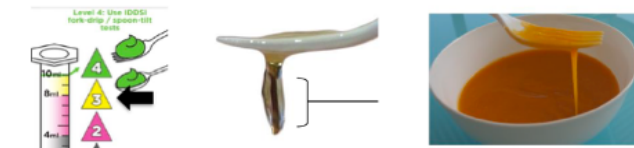

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c. Additional strategies to minimize risk of dehydration (<i>such as offer beverages with regular intervals, variety of beverages, offer small amounts frequently, etc.</i>):			
Diet Texture: Choose appropriate IDDSI Level(s); delete all other levels.			SLP, OT
IDDSI Level	IDDSI Description - <i>do not alter</i>	Testing Methods	
Level 7 Regular Food	<ul style="list-style-type: none"> • everyday foods of various textures • no texture or size restrictions at this level * unless noted by lead contact below 	<p><i>no specific tests needed for foods at this level</i></p>	
Level 7 Regular, Easy to Chew Food	<ul style="list-style-type: none"> • soft/tender textures • may be ‘mixed consistency’ per clinician • no size restrictions at this level * unless noted by clinician below <p>* must pass both the fork separation and fork pressure tests</p>		
Level 6 – Soft and Bite-Sized Food	<ul style="list-style-type: none"> • no separate thin liquid • mashes, stays squashed • chewing required before swallowing <p>* must pass both bite size requirement and fork pressure test</p>		
Level 5 – Minced and Moist Food	<ul style="list-style-type: none"> • can eat with fork or spoon • no separate thin liquid • easy to squash with tongue • small lumps <p>* must pass all 3: particle size requirement, fork pressure test, and spoon tilt test</p>		
Level 4 – Pureed Food	<ul style="list-style-type: none"> • usually eaten with a spoon • <u>no</u> lumps • <u>not</u> sticky • <u>cannot</u> be poured or drunk from a cup <p>* must pass both fork drip and spoon tilt tests</p>		
Level 3 Liquidized Food	<ul style="list-style-type: none"> • does not hold shape • no chewing required • smooth texture with no ‘bits’ <p>* must pass both flow and fork drip tests</p>		
Transitional Foods	<ul style="list-style-type: none"> • starts as one texture – changes to another with liquid or temperature • squashes and does not return to original shape 	 <p>1. Add 1mL of water to 1.5cm x 1.5cm sample and wait 1 minute.</p> <p>2. Then complete the IDDSI Fork Pressure Test.</p>	
Individual specific exceptions and/or restrictions (<i>If needed, specify foods that are allowed or restricted outside of the recommended IDDSI guidelines. This must be individualized per person, using clinical judgement</i>):			SLP, OT

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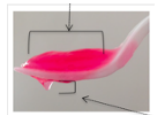

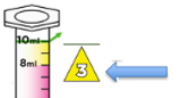


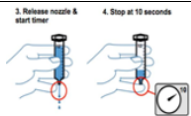
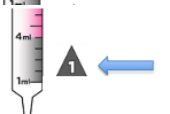
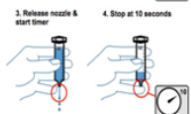

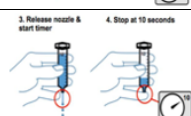
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STRATEGIES		PHOTOS (optional)	LEAD CONTACT*	
Instructions/Guidance for <u>preparation of food</u> for person <i>(describe blender/speed being used, fluids to add, etc.):</i>			SLP, OT	
Liquid Consistency: Choose appropriate IDDSI Level(s); delete all other levels.			SLP, OT	
IDDSI Level	IDDSI Description - <i>do not alter</i>	IDDSI Flow Test/Test Methods		
Level 4 Extremely Thick Liquid	<ul style="list-style-type: none"> • usually eaten with a spoon • <u>no</u> lumps • * must pass <u>both</u> fork drip and spoon tilt tests 	<ul style="list-style-type: none"> • not sticky • cannot be poured or drunk from a cup <div style="text-align: center;">  <div style="border: 1px solid black; padding: 2px; display: inline-block; margin: 5px;"> Holds shape, not firm or sticky </div>  </div>		
Level 3 Moderately Thick Liquid	<ul style="list-style-type: none"> • can be drunk with a cup or taken with a spoon • * must pass <u>both</u> flow and fork drip tests 	<ul style="list-style-type: none"> • smooth texture with no 'bits' • can be poured <div style="text-align: center;">  <div style="margin: 5px;"> at least 8mL left in the syringe </div>  </div>		
Level 2 Mildly Thick Liquid	<ul style="list-style-type: none"> • 'sippable' • pours quickly from a cup or spoon, but slower than thin drinks 	<div style="text-align: center;">  <div style="margin: 5px;"> 4 - 8mL left in the syringe </div> </div>	<div style="text-align: center;">  </div>	
Level 1 Slightly Thick Liquid	<ul style="list-style-type: none"> • thicker than water • requires a little more effort to drink than thin liquids 	<div style="text-align: center;">  <div style="margin: 5px;"> 1 - 4mL left in the syringe </div> </div>	<div style="text-align: center;">  </div>	
Level 0 Thin Liquid	<ul style="list-style-type: none"> • no liquid restriction • flows like water • fast flow 	<div style="text-align: center;">  <div style="margin: 5px;"> less than 1mL left in the syringe </div> </div>	<div style="text-align: center;">  </div>	
Individual specific exceptions and/or restrictions <i>(If needed, specify liquids that are allowed or restricted outside of the recommended IDDSI guidelines. This must be individualized per person, using clinical judgement):</i>			SLP, OT	
When liquids must be thickened, a commercial thickener or specific additive must be identified:		<input type="checkbox"/> N/A	SLP, OT	
Instructions/Guidance for <u>preparation of liquid</u> for person:				
Adaptive Eating Equipment <i>(identify by name, where used; photos are helpful. Include web links with ordering/purchasing information)</i>			OT, SLP	
1. Utensils: 2. Dishes:				

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STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
3. Cup (<i>specify style, lid, spout, straw, etc.</i>): 4. Cup for hydration outside of mealtime: 5. Mat: 6. Other (<i>blender/chopper, clothing protector, foot/back support, etc.</i>):		
Supervision when eating and/or drinking (<i>describe where the person supervising needs to be located</i>):		SLP, OT, BSC
Assisted Eating Techniques: how to assist the person with eating when another person is bringing the food and/or liquid to their mouth (<i>mark section N/A if the person brings food to their own mouth</i>): 1. Presentation of Food (<i>describe placement on lips or tongue, types of cues given, pacing, amount on spoon, alternating food and liquid sips, alertness strategies, etc.</i>): 2. Presentation of Liquid (<i>describe placement on lips or in mouth, types of cues given, pacing, amount of liquid in cup or per sip, etc.</i>):		SLP, OT
Self-Feeding Techniques: assistance needed for the person to safely bring the food and/or liquid to their own mouth (<i>mark section N/A if another person brings food/liquid to their mouth</i>): 1. Adaptive Equipment (<i>describe position of plate, utensils, cup</i>): 2. Communication Aid(s) (<i>describe basic use as part of self-feeding</i>): 3. Presentation of Food (<i>describe table set up, other ____</i>): 4. Presentation of Liquid (<i>describe location on table, set up, other ____</i>): 5. Cues needed (<i>for successful pacing, utensil use, other...</i>):		OT, SLP
Sensory Support (<i>describe strategies to support sensory needs and ensure safety during mealtime (e.g. alertness strategies, environmental modifications, food texture/temperature preferences)</i>):		OT, SLP
Behavioral Support (<i>include strategies to address risky eating behavior, prompts to address distraction, provide reassurance, combat food insecurity related to trauma, confusion, overstimulation, anxiety, motivation, etc.</i>):		BSC
Positioning after oral intake: Minimum length of time this position must be maintained:		PT, OT
D. ORAL MEDICATION DELIVERY STRATEGIES <input type="checkbox"/> Not applicable – 100% NPO or <input type="checkbox"/> ** Optional for REB Only (<i>if checked, delete both rows in section</i>)		

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<p>Forms of Medication:</p> <p>1. Refer to MAR for current medications & appropriate times for medication delivery. DO NOT LIST MEDICATIONS HERE.</p> <p>2. Describe the altered form of medications as needed due to sensory and/or dysphagia limitations (<i>check all that apply, if using multiple altered forms of medication specify type for each</i>)</p> <p><input type="checkbox"/> Liquid (<i>special instructions</i>):</p> <p><input type="checkbox"/> Crushed [assure medication is crushable] (<i>special instructions</i>):</p> <p><input type="checkbox"/> Cut into pieces no larger than _____, (<i>special instructions</i>):</p> <p><input type="checkbox"/> Whole (<i>special instructions</i>):</p> <p><input type="checkbox"/> Sprinkled on food (<i>special instructions</i>):</p> <p><input type="checkbox"/> Dissolved in liquid (<i>special instructions</i>):</p> <p><input type="checkbox"/> Other (describe):</p>		Nurse
<p>Oral Medication Delivery Method: <i>Indicate additional delivery techniques intended to minimize aspiration risk; check all that apply.</i></p> <p><i>Note: Level of Assistance with Medication Delivery is based on the MAAT: contact nurse with any questions.</i></p> <p><u>Liquid Medication/Medication Dissolved in Liquid:</u></p> <p><input type="checkbox"/> Drink using _____ (<i>specify cup type, straw, etc.</i>)</p> <p><u>Other Forms of Medication:</u></p> <p><input type="checkbox"/> Mix with _____ (<i>e.g. water, puree food, soft foods, etc.</i>)</p> <p><input type="checkbox"/> Present using _____ (<i>e.g. syringe, specific spoon, med cup, fingers, etc.</i>)</p> <p><input type="checkbox"/> Number of pills/tablets/capsules in mouth at one time</p> <p><input type="checkbox"/> Follow each oral presentation medication dose with _____ (<i>drink, puree food etc.</i>)</p> <p><input type="checkbox"/> Other:</p>		SLP
<p>E. TUBE (Enteral) FEEDING STRATEGIES via <input type="checkbox"/> G; <input type="checkbox"/> J; <input type="checkbox"/> G/J; or <input type="checkbox"/> NG tube</p> <p><input type="checkbox"/> Not applicable, no feeding tube (<i>if checked, delete all areas in tube feeding section below</i>)</p>		
<p>Nutritional Recommendations for Tube Feeding</p>		
<p>Do not list enteral feeding or water flush orders. Refer to MAR for the most current enteral feeding and water flush orders.</p> <p><input type="checkbox"/> Refer to more detailed Nutrition Plan, as needed.</p> <p>1. Nutrition goals:</p> <p>2. Recommended weight range:</p> <p>3. Caloric needs per 24 hours (For informational purposes; does not need to be tracked unless stated):</p> <p>4. Protein needs per 24 hours (For informational purposes; does not need to be tracked unless stated):</p> <p>5. Fluid needs per 24 hours (For informational purposes; does not need to be tracked unless stated):</p>		RD
<p>Tube Feeding Protocol (required) <input type="checkbox"/> = Indicates required content</p>		

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<ol style="list-style-type: none"> 1. List steps for checking tube placement (<i>describe, i.e., by checking mark on tube at exit site or n/a</i>): 2. List steps for checking residual, if <u>ordered by PCP or specialist</u> (<i>describe or n/a</i>): 3. List steps for setting up and/or connecting/disconnecting tube feeding including: <ol style="list-style-type: none"> a. <input type="checkbox"/> Aseptic/Clean technique for flushes (<i>describe</i>): b. <input type="checkbox"/> Total time allowed to hang: c. <input type="checkbox"/> Bolus vs. <input type="checkbox"/> Continuous (<i>describe</i>): d. <input type="checkbox"/> Other instructions: 4. Instructions for routine site care (<i>describe</i>): 5. Instructions regarding potential complications (<i>describe</i>): <ol style="list-style-type: none"> a. <input type="checkbox"/> When to discontinue feedings: b. <input type="checkbox"/> Notify nurse of vomiting: c. <input type="checkbox"/> Nurse will notify the PCP: d. <input type="checkbox"/> Instructions for what to do in case of change in tube length/displacement or dislodgement: e. <input type="checkbox"/> Instructions for abdominal pain, swelling or tenderness: f. <input type="checkbox"/> Instructions for redness/infections/erosion/drainage at site: g. <input type="checkbox"/> Monitor for signs of dehydration: h. <input type="checkbox"/> Other: 		Nurse
Medication Delivery via Tube <input type="checkbox"/> Not applicable (<i>if checked, delete row below</i>)		
Medication Delivery Method: Refer to MAR for Physician orders; including crush and flush orders <ol style="list-style-type: none"> 1. <u>Medications must never be added to formula.</u> 2. Medications must be given one at a time (<i>e.g. dissolved or crushed and mixed with water or other liquid as ordered by PCP</i>): 3. Assure medication is crushable. 4. Flush with water as ordered after each medication administration. 5. Other: 		Nurse
Positioning DURING and AFTER tube feeding, water flushes, and medication administration		
Describe general places the person may receive tube feeding, water flushes and medication administrations (<i>e.g. regular chair, wheelchair, bed, etc.</i>): <ol style="list-style-type: none"> 1. 2. 3. 		PT, OT
Positioning during tube feeding, water flushes & medication administration:		PT, OT

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Positioning after tube feeding, water flushes and medication administration: Minimum length of time this position must be maintained:		PT, OT
Activity or behavioral strategies during tube feedings		
1. Activity strategies:		OT, PT
2. Behavioral strategies (e.g., <i>distraction, redirection prompts, use of abdominal binder to minimize risk of pulling tube, etc.</i>):		BSC
F. POSITION FOR ROUTINE ACTIVITIES		
<input type="checkbox"/> Determined not applicable based on assessment & IDT consensus (if checked, delete row below)		
Positioning for (<i>photos are helpful</i>): <input type="checkbox"/> Refer to more detailed WDSI, as needed. 1. Bed: 2. Showering or bathing: 3. Personal care (e.g. <i>Attends changes, dressing etc.</i>): 4. Swimming: 5. Rest or leisure: 6. Other (<i>vehicle transport, etc.</i>):		PT, OT
G. ORAL HYGIENE STRATEGIES (required)		
** if REB only <input type="checkbox"/> Determined not applicable based on assessment & IDT consensus (if checked, delete all areas in oral hygiene section below)		
Please check all that apply (<i>for team information only</i>): <input type="checkbox"/> own teeth (all present) <input type="checkbox"/> own teeth (some missing) <input type="checkbox"/> no teeth <input type="checkbox"/> partial plate/dentures used <input type="checkbox"/> partial plate/dentures refused		
1. Complete Oral Care times per day.		Nurse
2. Identify when oral care should occur:		OT
3. Recommended Location(s) for oral care:		
4. List and describe ALL needed oral hygiene supplies (including those identified by the team and <u>prescribed/recommended</u> per the Dentist/Oral Hygienist): 4.1. Mouthwash/solutions (<i>refer to MAR if ordered</i>): 4.2. Toothpaste (<i>refer to MAR if ordered</i>): 4.3. Toothbrush(es): 4.4. Floss/floss piks: 4.5. Other (<i>include partial/denture care as needed</i>):		Nurse, OT, SLP
5. Utilize good oral hygiene practices as recommended by Dentist/Oral Hygienist or identified by the team (<i>include detailed instructions in sections 8 and 9</i>):		Nurse, OT

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STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
5.1. Brushing time: 5.2. Flossing: 5.3. Partial/Denture care:		
6. Positioning of person during oral care:		OT, PT
7. Positioning of person assisting with oral care (<i>indicate N/A if not needed; include instructions for person supervising below</i>):		OT, PT
8. Instructions for Brushing, Flossing and/or Mouthwash recommended by Dentist/Oral Hygienist or as identified by team. <u>Brushing (choose one)</u> : <input type="checkbox"/> N/A <input type="checkbox"/> Self-Brushing <input type="checkbox"/> Self-Brushing and Assisted Brushing <input type="checkbox"/> Assisted Brushing Describe steps: (<i>set up, supervision, placement in mouth, time per mouth quadrant, types of verbal/gestural/physical cues or assist, pacing, sensory strategies, etc.</i>) • <u>Mouthwash (choose one)</u> : <input type="checkbox"/> N/A <input type="checkbox"/> Self-Use <input type="checkbox"/> Self and Assisted-Mouthwash Use <input type="checkbox"/> Assisted-Mouthwash Use Describe steps: (<i>set up, supervision, placement in mouth, time per mouth quadrant, types of verbal/gestural/physical cues or assist, pacing, sensory strategies, etc.</i>) • <u>Flossing (choose one)</u> : <input type="checkbox"/> N/A <input type="checkbox"/> Self-Flossing <input type="checkbox"/> Self-Flossing and Assisted Flossing <input type="checkbox"/> Assisted Flossing Describe steps: (<i>set up, supervision, placement in mouth, time per mouth quadrant, types of verbal/gestural/physical cues or assist, pacing, sensory strategies, etc.</i>) •		OT, SLP, Nurse
9. Behavioral or Sensory Supports for Oral Care Routine <u>not included</u> above:		BSC, OT, SLP, Nurse
10. Saliva management techniques <u>during oral care not previously stated</u> (e.g. suctioning, etc.):		Nurse, SLP, OT, PT
11. Observe for and report to nurse any: 11.1. Change in appearance of gums or tongue; (e.g. dark, broken, loose or missing teeth; bad breath; swelling, lesion).		Nurse

* **“Lead Contact”** is responsible for monitoring and training each strategy area. Suggested Discipline is **Bolded**. The team must identify one Lead Contact for each area and delete other disciplines. Add Designated Trainer’s name under Lead Contact following designation; the Lead Contact must continue to monitor and report. N=Nursing, RD=Registered/Licensed Dietitian; PT=Physical Therapy; OT=Occupational Therapy; SLP=Speech Therapy; BSC=Behavior Support Consultant NM HCA-DDSD 3/1/2026

Comprehensive Aspiration Risk Management Plan (CARMP)

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STRATEGIES	PHOTOS (optional)	LEAD CONTACT*
11.2. Presence of oral pain, refusal to eat or drink hot/cold food or liquids etc. 11.3. Stop oral care immediately and contact nurse if:		
12. Positioning AFTER oral care: Minimum length of time this position must be maintained:		PT, OT
H. SALIVA MANAGEMENT STRATEGIES <input type="checkbox"/> Determined not applicable based on assessment & IDT consensus <i>(if checked, delete areas below)</i>		
Positioning: 1. Lying down: 2. Sitting: 3. Other <i>(consider position of persons who interact with the person to minimize risk, i.e., do not stand above the person seated):</i>		PT, SLP, OT
Skin/Clothing Protection:		Nurse, SLP, OT
Medical strategies: <input type="checkbox"/> Medication (routine or PRN medications used to control oral secretions): <input type="checkbox"/> Suction: 1. Type of suction catheter: 2. Size of suction catheter: 3. <input type="checkbox"/> Oral or <input type="checkbox"/> Tracheal suctioning 4. Frequency to apply suction: <input type="checkbox"/> Other instructions: <input type="checkbox"/> Contact nurse for: Nurse will contact PCP when indicated.		Nurse
Other Strategies (if any):		BSC
I. STRATEGIES TO MINIMIZE RUMINATION <input type="checkbox"/> Determined not applicable based on assessment & IDT consensus <i>(if checked, delete areas below)</i>		
Sensory Strategies:		OT
Positioning Strategies:		PT, OT
Behavioral Strategies <i>(include techniques to address external or internal factors, communication options, oral stimulation items, differential reinforcers, prompts, etc.):</i>		BSC

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STRATEGIES		PHOTOS (optional)	LEAD CONTACT*
J. PERSONALIZED OUTCOMES (required)			
<i>Note: Outcomes must be measurable. Timeline for each outcome will be through the ISP term. If timeline is different than this, PLEASE SPECIFY!</i>			
The IDT will track the following outcomes to determine the effectiveness of the CARMP			IDT: develops CM: assures IDT tracks outcomes
1.			
2.			
K. LEAD CONTACT INFORMATION (required for ALL) Use SCOMM only for all communication and scheduling			
Name	Agency	Phone	NOTES
Primary Provider Nurse: RN: RD: SLP: PT/PTA: OT/COTA: BSC:			
L. EMERGENCY CONTACT INFORMATION (required for ALL)			
Name	Agency	Phone	NOTES
GUARDIAN: HOSPITAL: PCP: OTHER: OTHER:			

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