FUNCTIONAL ASSESSMENT AND REMEDIATION OF (TETHERED ORAL TISSUES) TOTs

CASE HISTORY FORM | TOTs PROTOCOL FORM

THERAPY SESSION FORMS

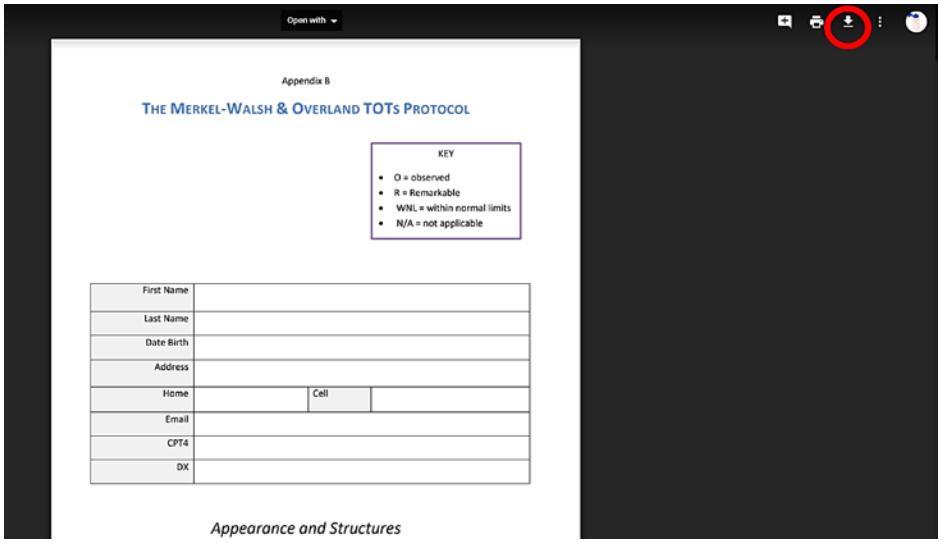
This booklet contains forms included in the *FUNCTIONAL ASSESSMENT AND REMEDIATION OF TOTs* book

- Appendix A – MERKEL-WALSH & OVERLAND TOTs CASE HISTORY FORM
- Appendix B – MERKEL-WALSH & OVERLAND TOTs PROTOCOL FORM

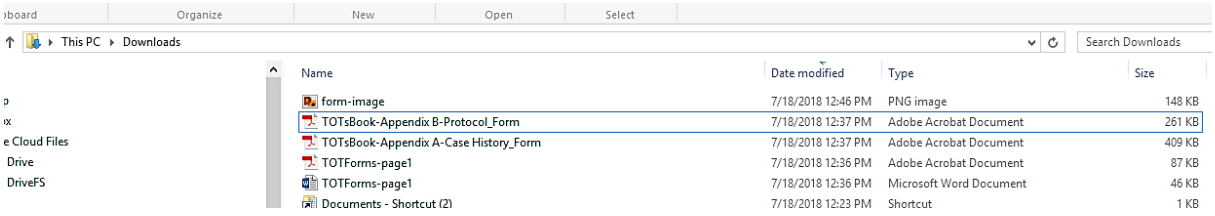
These forms are ready to use in your therapy sessions – either:

1. follow links below to download the electronic form, which can be accessed and completed on your laptop or mobile device:

- click on download icon on top right of your screen to save to your downloads folder on your computer/device

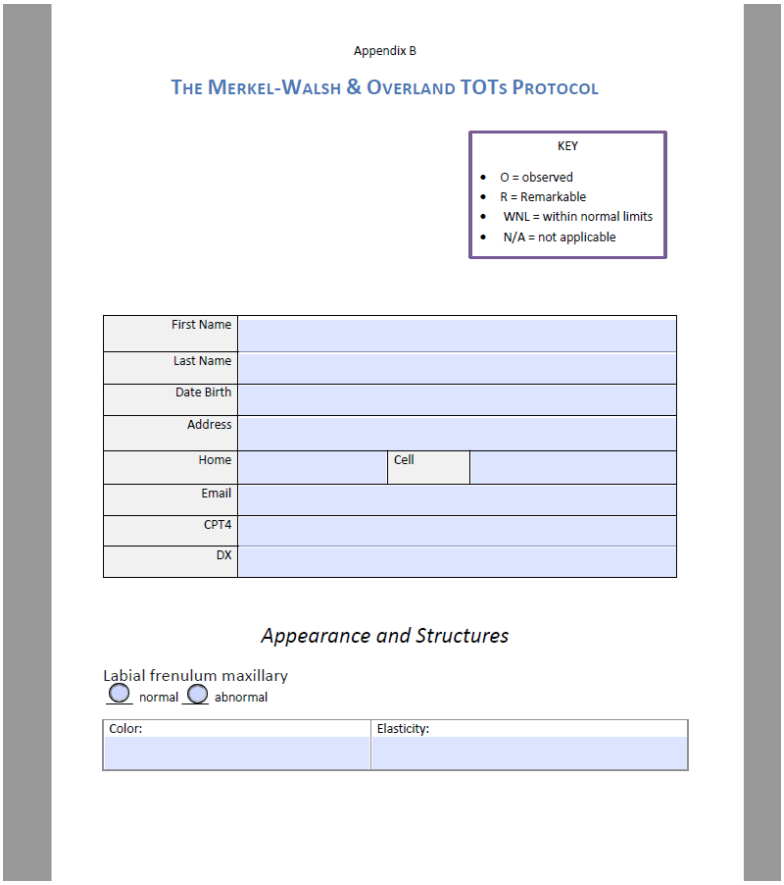


- go to your downloads folder and



locate file

- open file, complete form via fillable fields



Appendix B

THE MERKEL-WALSH & OVERLAND TOTS PROTOCOL

KEY

- O = observed
- R = Remarkable
- WNL = within normal limits
- N/A = not applicable

First Name			
Last Name			
Date Birth			
Address			
Home		Cell	
Email			
CPT4			
DX			

Appearance and Structures

Labial frenulum maxillary

◯ normal ◯ abnormal

Color:	Elasticity:

- Save file to computer or device – it is recommended to create a FORMS folder on your computer/device, name form with a standard naming convention (ex., client name and date form is completed) and save completed form to FORMS folder

Appendix A

MERKEL-WALSH & OVERLAND

CASE HISTORY FORM

First Name			
Last Name			
Date Birth			
Address			
Home		Cell	
Referring Physician			
Date of Report			

Birth History

(please provide details where applicable)

Question	Yes	No
Were there any complications during pregnancy	◯	◯
Did you carry your baby full term?	◯	◯
Were there problems during delivery?	◯	◯
Did your baby require any special care after delivery?	◯	◯

Birth weight	
Percentile of weight	
Length/height	
Percentile of length/height	
Apgar Score	

Medical History

Question	Yes	No
Does your child have a medical or educational diagnosis?	◯	◯
Has your child ever been on medication?	◯	◯
Is your child currently on medication?	◯	◯

Does your child have any of the following? *(check all that apply)*

☐	Frequent Colds	☐	Seasonal allergies
☐	Chronic Congestion	☐	Food allergies
☐	Asthma	☐	Hearing Issues
☐	Cardiac Issues	☐	Constipation
☐	Tracheomalacia	☐	Frequent spit-up
☐	Reflux/GERD	☐	Snoring
☐	Failure to thrive	☐	Bed-wetting
☐	Diagnosis of sleep apnea	☐	Recurrent middle-ear infections
☐	Laryngomalacia	☐	Diarrhea
☐	Frequent vomiting (after six months of age)	☐	Restless sleep

Dental History

Question	Yes	No
Has your child been seen by a dentist?	◯	◯
Does the dentist have any concerns about structure? *(If yes, check all that apply below)*	◯	◯

☐	High Palate	☐	Teeth Grinding/Bruxism
☐	Cavities	☐	Plaque
☐	Lip-Tie	☐	Spaces between teeth
☐	Crowding	☐	Tongue-Tie
☐	Thrush	☐	Frequent spit-up

Feeding History

Was your baby breast- or bottle-fed?

☐	Breastfed	☐	Bottle-fed

How did you originally plan to feed your baby?

Question	Yes	No
Are there any concerns about nutritional status?	◯	◯
Do you have any concerns about feeding safety?	◯	◯
Has your child had a swallow study? (If so please attach the results)	◯	◯

Did you seek assistance with breastfeeding?	PCP	☐	Lactation Consultant (IBCLC)	☐	SLP	☐

Question	Yes	No
Was a lip-tie or tongue-tie identified?	◯	◯
Were you encouraged to see/discouraged from seeing a specialist?	◯	◯
Did you child have any difficulty breastfeeding/bottle-feeding (if yes, please check all that apply below)	◯	◯

☐	Difficulty latching	☐	Reflux
☐	Coughing	☐	Gagging
☐	Crying	☐	Dribbling
Other:			

At what age did you introduce spoon-feeding?

Question	Yes	No
Did your child have any difficulty with smooth pureed food? (if yes, please check all the apply below)	◯	◯

☐	Coughing	☐	Spitting out food
☐	Vomiting	☐	Choking
☐	Gagging	☐	Food Refusal
Other:			

Question	Yes	No
Did your child have any difficulty with chunky pureed food? (if yes, please check all the apply below)	◯	◯

☐	Coughing	☐	Spitting out food
☐	Vomiting	☐	Choking
☐	Gagging	☐	Food Refusal
Other:			

At what age did you introduce solid foods?

Question	Yes	No
Did your child have any difficulty with dissolvable solids (ex., Cheerios, Puffs) (if yes, please check all the apply below)	◯	◯

☐	Coughing	☐	Spitting out food
☐	Vomiting	☐	Choking
☐	Gagging	☐	Food Refusal
Other:			

Question	Yes	No
Did your child have any difficulty with soft vegetables/fruits? (if yes, please check all the apply below)	◯	◯

☐	Coughing	☐	Spitting out food
☐	Vomiting	☐	Choking
☐	Gagging	☐	Food Refusal
Other:			

At what age did your child stop breast- or bottle-feeding?

Question	Yes	No
Did your child have difficult transitioning to a straw?	◯	◯
Did your child have difficulty transitioning to a cup?	◯	◯
Is your child on a special or restricted diet (e.g., glute-free, dairy-free) (If yes, please describe below)	◯	◯
Does your child have a self-limited diet? (e.g., gluten-free, dairy-free) (if yes, please describe below)	Yes ◯	No ◯
Does your child have food aversions? Please indicate difficulties with taste, texture, temperature, color, size and/or shape	Yes ◯	No ◯
Are mealtimes longer than normal?	Yes ◯	No ◯
Would your child prefer to graze rather sit for a meal?	Yes ◯	No ◯

Please chart what your child eats (item and amount) in the following *Five-Day Baseline Diet*:

Five-Day Baseline Diet

	Day 1	Day 2	Day 3	Day 4	Day 5
Breakfast					
Snack					
Lunch					
Snack					
Dinner					
Snack					

Oral-Motor/Oral Habits

Question	Yes	No
Has your child had excessive drooling?	○	○
Does your child suck his/her thumb or digits?	○	○
Did your child use a pacifier? (if yes, enter how long below	○	○
Does your child exhibit open-mouth posture and mouth breathing?	○	○

Oral-Motor/Oral Habits

Is your child's speech intelligible to the familiar listener?

☐	<25%	☐	25-50%	☐	50-75%	☐	75%

Is your child's speech intelligible to the unfamiliar listener?

☐	<25%	☐	25-50%	☐	50-75%	☐	75%

Does intelligibility change as your child moves from single words to sentences?

Question	Yes	No
Do you have any concerns about sound production? (If yes, what sound(s) does your child have difficulty producing (circle sounds that apply)	◯	◯

If yes, what sound(s) does your child have difficulty producing (check sounds that apply)?

b ☐	m ☐	p ☐	w ☐	t ☐	d ☐	n ☐	l ☐	k ☐	
g ☐	h ☐	r ☐	sh ☐	ch ☐	j ☐	s ☐	z ☐	j ☐	
r ☐ blends	l ☐ blends	s ☐ blends	k ☐ blends	th ☐	Vowels				

Therapy

Question	Yes	No
Has your child been seen a lactation specialist? If yes, please provide name below	◯	◯
Has your child been seen for feeding therapy (If yes, please provide name of treating therapist below	◯	◯
Has your child been seen for speech therapy? (If yes, please provide name of treating therapist below)	◯	◯

Additional Information (Feel free to use the back of this form.)

Appendix B

THE MERKEL-WALSH & OVERLAND TOTS PROTOCOL

KEY

- O = observed
- R = Remarkable
- WNL = within normal limits
- N/A = not applicable

First Name			
Last Name			
Date Birth			
Address			
Home		Cell	
Email			
CPT4			
Diagnosis			

Appearance and Structure

Labial frenulum maxillary

◉ normal ○ abnormal

Color:	Elasticity:

Location:	Kotlow classification:
	Class I: ☐ Class II: ☐ Class III: ☐ Class IV: ☐
Notes:	

Labial frenulum mandibular

◯ normal ◯ abnormal

Color:	Elasticity:
Blanching upon depression of the lower lip ☐ yes ☐ no	
Location:	
Notes:	

Buccal frenulum

◯ normal ◯ abnormal

Color:		Elasticity:	
Blanching upon elevation/depression of the upper lip? ☐ yes ☐ no			
Location			
Upper right: ☐	Upper left: ☐	Lower right: ☐	Lower left: ☐
Notes:			

Lingual frenulum

◯ normal ◯ abnormal

Color:			Elasticity:		
Location:			Coryllos & Genna classification:		
			Type 1: ☐	Type 2: ☐	Type 3: ☐ Type 4: ☐ Type 5: ☐
			Kotlow Rating Scale:		
			Class I: ☐	Class II: ☐	Class III: ☐ Class IV: ☐
Notes:					

Facial features

Bone Structure	Notes:	Side Profile	Notes:
Mesocephalic (normal)		Straight	
Dolichocephalic (narrow angles)		Convex	
Brachycephalic (wide angles)		Concave	
Symmetrical		High nasiolabial angle	
Asymmetrical		Airway	
High palate		Tonsils	
Wide palate		Adenoids	
Narrow palate		Uvula	
Flat palate		Nostrils/Nasal Airway	
Clefting			

Dentition

	Notes:		Notes:
Class I		Open bite	
Class II		Diastemas	
Class III		Loose teeth	
Overbite		Missing teeth	
Underbite		Crowding	
Overjet		Gingival issues	

Orthodontic appliances		Tooth decay	
Inversion of teeth		Plaque buildup	

Function

Range of motion

	Notes:		Notes:
Lip closure		Lingual retraction	
Lip protrusion		Lingual lateralization	
Lip rounding		Tongue-tip elevation	
Lip retraction		Tongue-tip depression	
Lingual protrusion		Back-tongue side spread	
Lower-lip retraction		Additional	
N = nonspeech oral imitation		F = facilitated	

Pre-Feeding

Reflexes	Notes:
Rooting reflex	
Suck reflex	
Suck-swallow reflex	
Phasic bite reflex	
Lateral tongue reflex	
Gag reflex	

Pre-Feeding Skills	Notes:
Lip closure (pre-feeding for spoon and cup)	
Lip rounding (pre-feeding for breast/bottle/straw)	
Nonnutritive repetitive lateral bite (pre-feeding for chewing)	
Tongue protrusion (pre-feeding basic suck)	
Tongue retraction (breast/bottle/spoon/cup/straw/solids)	
Tongue lateralization (moving a bolus)	
Tongue-tip elevation and depression (mature swallow/true suck)	

Feeding

Skill	Notes:
Breast-feeding	
Bottle-feeding	
Spoon-feeding	
Introductory solids	
Cup-drinking	
Straw-drinking	
Advanced solids	

Articulation

Placement	Phoneme	Buccal TOTS	Labial TOTs	Lingual TOTs
Lip closure	m			
	b			
	p			
Tongue retraction with blade elevation	n			
	d			
	t			
Tongue retraction with back elevation	ʒ			
Lip rounding	w			
Lower-lip retraction	f			
	v			
Low jaw	h			
Tongue retraction with back elevation and blade/tip down	k			
	g			
Tongue retraction with lip elevation	l			
Tongue retraction with tip elevation/depression slight protrusion	s			
	z			
Tongue side spread lip protrusion	ʃ			
	tʃ			
	dʒ			
Tongue retraction with side spread and lower-lip tension	r			
Tongue protrusion	θ			
	ð			

Additional Concerns

	Notes:		Notes:
Breathing		Allergies	
Oral rest posture		Nasal congestion	
Oral habits		Ear infections	
Sleeping		Airway	