State of Illinois
Department of Healthcare and Family Services

Questionnaire for Food Thickeners

Time Period: From _______________ To _______________

☐ Initial Request ☐ Renewal Request ☐ Change in Prescription

1. Participant Information: Participant Name _______________ RIN _______________

Birth Date _______________

2. Participant General Condition: Height: _______________ Weight: _______________

Primary Diagnosis Related to Need for Food Thickener: _______________

Additional Diagnoses: _______________

3. Food Thickener:

Estimated Duration of Need for Food Thickener: Months _______ Years _______ Lifetime _______

Product (B4100): _______________ Container size: _______________

Consistency: Thin ☐ Nectar ☐ Honey ☐ Pudding ☐

Specific Instructions for Use:

Quantity used per day: Tbsp. _______________ or Packets: _______________

4. Clinical Assessment:

Is there any past medical history associated with aspiration pneumonia? Yes (**provide clinical documentation**) ☐ No ☐

What is the level of dysphagia?
(**provide clinical documentation**) Oral _______________ Pharyngeal _______________ Esophageal _______________

Has the participant had a dynamic swallowing study (video-fluoroscopic swallowing study) in conjunction with a speech language pathologist? Yes (**provide detailed report**) ☐ No ☐

5. Certification:

Physician's Name _______________ Specialty _______________ Phone # _______________

Practitioner's Signature _______________ with Degree _______________

Supervising or Collaborating Physician If Signing Practitioner Is Not an M.D. or D.O.:

NPI _______________ Date _______________ Office Phone # _______________ Fax _______________