1. Gathering clinical data from your patients is an example of which portion of EBP?
    a. Clinical expertise/expert opinion
    b. Internal evidence
    c. External evidence
    d. Patient & caregiver perspectives

2. The penetration-aspiration scale is:
    a. Quantitative, Objective, and Ordinal
    b. Quantitative, Subjective, and Nominal
    c. Quantitative, Subjective, and Ordinal
    d. Quantitative, Objective, and Continuous

3. The Modified MASA does not involve any swallowing observations
    a. True
    b. False

4. Your patient has UES dysfunction. What can we use to quantify UES functioning?
    a. MBSS - UES opening measurement
    b. MBSS - normalized residue rating scale
    c. Pharyngeal high-resolution manometry
    d. Submental surface EMG
    e. All of the above
    f. A and C
    g. A and D

5. The modified barium swallow study will tell us if our patient has a weak swallow
    a. True
    b. False

6. What tool captures pharyngeal residue from the oropharynx, hypopharynx, epiglottis, laryngeal vestibule, vocal folds, and subglottis?
    a. Yale Residue Rating Scale
    b. Normalized Residue Ratio Scale
    c. DIGEST-FEES
    d. VASES

7. The DIGEST would be appropriate to use in patients following stroke, as that was the population it was validated on
    a. True
    b. False

8. Impedance, when added to pharyngeal high-resolution manometry tells us about:
    a. Airway invasion
    b. Bolus flow along the pressure catheter
    c. Oral phase functioning
    d. Pressure generation

9. MBSS kinematic measurements are often normalized to which distance?
    a. C1 to C3
    b. C1 to C4
    c. C2 to C3
    d. C2 to C4

10. A pharyngeal constriction ratio of greater than 0.25 is associated with reduced pharyngeal pressures
    a. True
    b. False