



# Pediatric Feeding and Swallowing Services Referral Form

Child Youth & Family Health Rehab Services

Queen Alexandra Centre for Children's Health

2400 Arbutus Road Victoria, BC V9B 3A1

Phone: 250-519-6763 or 250-519-6967 Fax: 250-519-6918

Referral date:     /     /

MRN:

**CLIENT INFORMATION**

Surname:	First Name:	Middle Name:
PHN:	DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Parent(s)/Legal Guardian name:		
Address:		
City:	Province:	Postal code:
Home #:	Cell #:	Email:
Spoken languages: <input type="checkbox"/> English <input type="checkbox"/> Other:		Interpreter required: <input type="checkbox"/> Y <input type="checkbox"/> N
Client/family aware of the referral: <input type="checkbox"/> Y <input type="checkbox"/> N		

**REFERRAL SOURCE**

Name:	Agency:	
Tel #:	Fax #:	Email:
Relationship to client:		

**REASON FOR REFERRAL**

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**MEDICAL INFORMATION**

Primary diagnosis:
Other medical conditions:

**SOCIAL INFORMATION**

<input type="checkbox"/> No concerns	<input type="checkbox"/> Followed by social worker	<input type="checkbox"/> Financial/housing concerns	<input type="checkbox"/> Family stressors
<input type="checkbox"/> Emotional distress	<input type="checkbox"/> Child protection concerns	<input type="checkbox"/> Child in foster care	<input type="checkbox"/> Family strengths
Other / comments:			

MEDICAL SUPPORT	NAME AND AGENCY	CONTACT INFORMATION
Physician / pediatrician		
Dietitian		
Occupational therapist		
Physical therapist		
SLP		
Social worker		
Other:		

**INCLUDE ALL APPLICABLE AND RELEVANT DOCUMENTATION**

<b>Surname:</b>	<b>First Name:</b>
<b>DOB:</b>	<b>PHN:</b>
<b>FEEDING AND NUTRITION INFORMATION</b>	
(current diet order, feeding methods, ...)	
Feeding method: <input type="checkbox"/> Oral <input type="checkbox"/> Tube <input type="checkbox"/> Combination	
Other / comments:	
<b>GROWTH AND NUTRITIONAL CONCERNS</b>	
<input type="checkbox"/> No concerns	<input type="checkbox"/> Poor weight gain or <input type="checkbox"/> weight loss <input type="checkbox"/> Feeding intolerance
<input type="checkbox"/> Followed by local dietitian	<input type="checkbox"/> Excessive weight gain <input type="checkbox"/> Poor appetite or <input type="checkbox"/> refusal to eat
<input type="checkbox"/> No known local dietitian	<input type="checkbox"/> Inappropriate diet for age <input type="checkbox"/> Food group restrictions
Other / comments:	
<b>MEDICAL AND FEEDING CONCERNS</b>	
<input type="checkbox"/> Food allergies / intolerances	<input type="checkbox"/> Confirmed impaired swallow <input type="checkbox"/> Oral aversions
<input type="checkbox"/> Frequent respiratory illness	<input type="checkbox"/> Choking or <input type="checkbox"/> coughing with meals <input type="checkbox"/> Gagging or <input type="checkbox"/> emesis with meals
<input type="checkbox"/> Texture restrictions	<input type="checkbox"/> Wet voice with meals <input type="checkbox"/> Oral-motor difficulties
<input type="checkbox"/> Constipation or <input type="checkbox"/> diarrhea	<input type="checkbox"/> Behavioral concerns
<input type="checkbox"/> GERD / frequent spit-ups or emesis / arching with meals / crying with meals	
Other / comments:	
<b>ADDITIONAL INFORMATION OR CONCERNS</b>	