FEEDING REFERRAL FOR INVOLVEMENT OF THE CHILDREN'S SPEECH & LANGUAGE THERAPY SERVICE

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

This referral is for an assessment of feeding skills only (biting, chewing and swallowing). We are not able to assess those children who are experiencing behavioural feeding difficulties

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Child's First Name(s):…… **Surname:** ……

NHS Number:..... **Sex**: Male ☐ / Female ☐

Date of Birth: …… **Age:**……..

Address: ……

…….. **Postcode**: ……

Named Carer(s):…….. **Telephone**: ……

Mobile: ……

School/Nursery:...…….. **Year Group**: ……

GP: …….. **Practice**: ……

Home Language: ..... **Interpreter Required?** Yes ☐ No ☐

Medical History:

Medical diagnosis (if known):.....…….

Is the child generally delayed in other areas? (If so, is feeding in line with these skills?)……...

Any medication taken……

Any significant health problems?: ……

Any allergies or food intolerances?.....

Current Support Services:

Support Service	Contact Name
☐ Paediatrician	
☐ Physiotherapist	
☐ Occupational Therapist	
☐ Educational Support	
☐ Health Visitor	
☐ School Nurse	
☐ Social Care	
☐ Family Support Worker	
☐ Dietician	
☐ Other	

Reason for Referral:

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……

Feeding History:

At what age was the child first weaned? …… .

What types of food does the child eat now? (Including types of texture eg chopped, lumpy or smooth)

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What utensils are used? ……...

Does the child feed independently? (are they overloading the spoon or mouth?)

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Have you observed the child feeding, if so what did you observe?

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Are there sensory patterns relating to the food that the child accepts or refuses? (e.g. colour/temperature).....

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Does the child show other sensory sensitivities? (e.g. doesn't like loud noises, getting hands dirty?)……

……

Please tick if any of the following apply during/ after feeding:

Coughing during or after feeds ☐

Choking during or after feeds ☐

Poor weight gain ☐

Frequent chest infections (more than 3 in a year) ☐

Vomiting following food/feeds ☐

Wheezing after feeding ☐

Eyes watering, blinking, widening during feeds ☐

Tires easily during feeds/meals ☐

Restricted diet ☐

Gagging on food ☐

Difficulties managing secretions ☐

Noisy or wet sounds during or after feeding ☐

Change in breathing rate during feeds ☐

Grimacing during feeds ☐

Change in colour during feeds ☐

Previously Known to Speech & Language Therapy? Yes ☐ No ☐
If **Yes**, please state reason for re-referral: .....

……

Any Other Information You Feel Would Be Useful:

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Prior to sending this referral please consider the pre referral strategies and information given which may be useful in resolving the current feeding issues.

Referrer Information:

Referral completed by:	Name:	……..
	Signature:	……..
	Position:	……..
	Base/ Address	……..
	Contact telephone number:	……..
Date form completed:	……..	

Parental Consent:

I agree to my child being referred to the Speech and Language Therapy Service and understand I will need to attend a clinic appointment.

Parent / carer name: ……..

Relationship to child: ……..

Parent / carer signature: …….. Date: .....

Please Note: Any incomplete forms will be returned to the referrer.

WHEN YOU HAVE COMPLETED THIS FORM PLEASE SEND IT TO:

CHILD DEVELOPMENT CENTRE, DONCASTER ROYAL INFIRMARY, ARMTHORPE ROAD, DN2 5LT