**Feeding Service- Referral form**

**Please note that all referrals to the Feeding Service are centralised and then triaged to the appropriate clinic based on the information provided/needs of the child. Please ensure you complete the form fully to ensure the child is allocated to the appropriate clinic and to prevent delays.** Please note referrals are only accepted from paediatricians. As a specialist service, we work in partnership with professionals such as local paediatrician, dieticians and therapists. We operate on a package of care basis and as such we expect referrals to our service to also remain open to local services.

**We require the following to be submitted with the referral**

* **Dietetic Report**
* **Paediatrician report**
* **Up to date growth measurements, physical examination +/- investigations including any blood tests**
* **Other support e.g SALT Report/OT report**
* **Evidence of local feeding support e.g parent support groups/previous intervention tried**

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| **SECTION 1: Patient details** | |
| Child’s first name |  |
| Child’s surname |  |
| D.O.B |  |
| NHS no. |  |
| Address |  |
| Parent or Guardian name |  |
| Parental responsibility (name and relationship) |  |
| Email |  |
| Home/Mobile Tel no. |  |
| Interpreter required? |  No  Yes – the language required is |
| Specialist needs | Is the child on a Child Protection Plan or a Child in Need?   No  Yes- please give details  Is the child looked after (i.e. under the care of the Local Authority)?   No  Yes- please give details |
| GP Details |  |

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| **SECTION 2: Clinical details** | |
| Reason for referral *This should include your clinical question*  **NB- This is a tertiary feeding service and referrals will not be accepted without evidence of prior local service intervention e.g. reports** |  Diagnostic assessment   Second opinion of feeding/eating and drinking skills   Tertiary level MDT intervention required   Additional support for family in conjunction with local team input  **Please state clinical question: Including query regarding feeding diagnosis, impact on general health, growth, family and other needs** |
| Main medical diagnosis/es |  |
| Relevant medical/surgical history  *This should include all gastroenterology, cardiac, renal, metabolic, neurological or other history.* | Birthweight. Perinatal care. |
| Investigations and input to date including assessments and interventions by local team **(please attach any relevant reports)** |  Barium meal   Videofluoroscopy   Clinical swallowing assessment   Feeding group   Feeding clinics (hospital and community clinics attended/attending)   Other (please detail) |
| Medications *Please include all relevant medications including gastroesophageal reflux medications* |  No   Yes – *please give details:* |
| Allergies and sensitivities |  No   Yes – *please give details:* |
| Brief Feeding History *please outline brief feeding history e.g feeding at birth, weaning, when difficulties started* |  |

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| **Summary of feeding/eating & drinking difficulties** | |
| Is the child fully orally fed? |  Yes   No – NG / PEG / PEGJ / TPN / Other |
| How much does the child take orally vs tube? |  |
| Saliva management *e.g. at rest, on activity, during and after eating & drinking. Any medical or behavioural management.* |  No concerns   Yes concerns  If yes please add further details on how this is being managed: |
| Current feeding/ eating & drinking concerns *e.g. SLT/parent/school.* |  Difficulty swallowing   Difficulty chewing   Difficulty progressing to age appropriate textures   Restricted diet-  range  presentation textures   Limited number of foods <5 <10 <20   Sensory skills. Does the child have difficulty touching/smelling foods   Anxiety around food and mealtimes  child carer   Difficulty with behaviour with food and mealtimes   Social communication disorder   Other |
| Is weight or nutrition of concern?  Is hydration of concern? |  No  Yes if yes, how   No  Yes  Date measured  Weight: Centile  Height/length: Centile  Date measured  Previous Weight: Centile  Previous Height/length: Centile |
| Previous therapeutic intervention  Referral will be rejected if there is no evidence that has been offered locally |  Speech and Language Therapy   Dietetic input   Occupational Therapy   Psychology   CAMHS   Child group intervention e.g. messy play/fun with food groups   Parent education – please specify type of education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **SECTION 3: Local professionals involved** | | |
| **Profession** | **Name and contact details** | **Currently involved** |
|  Paediatrician (must be open to paediatrician even if not routinely reviewed) | Name:  Address:  Telephone:  Email: |  Yes   No |
|  Speech and Language Therapist | Name:  Address:  Telephone:  Email: |  Yes   No |
|  Dietitian (we expect all referrals to have ongoing review by local dietician) | Name:  Address:  Telephone:  Email: |  Yes   No |
|  Occupational Therapist | Name:  Address:  Telephone:  Email: |  Yes   No |
|  Psychologist/CAMHS | Name:  Address:  Telephone:  Email: |  Yes   No |
|  Physiotherapist | Name:  Address:  Telephone:  Email: |  Yes   No |
|  Health visitor | Name:  Address:  Telephone: Email: |  Yes   No |
|  Other | Name:  Address:  Telephone:  Email |  Yes   No |

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| **Name of nursery/school child attends** |
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| **Have you gained parental consent to contact school?**  Yes  No |
| **If Yes, name and contact details of appropriate person in school:** |
|  |

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| **SECTION 4: Consent** | |
| Has the referring clinician gained verbal consent & discussed purpose of this referral with the child/parents? |  Yes   No Reason ……………………………………………………………………………. |

**Additional comments**

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**Referrers contact details**

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| **Signed** |  | **Telephone** |  |
| **Name** |  | **Address** |  |
| **Designation** |  |
| **Date** |  | **Email** |  |

**Please complete and return with the attached food diary and any relevant reports to:**

**The Feeding Service, Floor 2, Becket House, Evelina London Children’s Hospital, St Thomas’ Hospital, Westminster Bridge Rd, London SE1 7EH or email completed form to** [**Gst-tr.elchpaedneuroreferrals@nhs.net**](mailto:Gst-tr.elchpaedneuroreferrals@nhs.net)

**Please note forms without the required information will be rejected** 