KidsInclusive EnfantsInclus
Centre for Child & Youth Development
Centre du développement des enfants et des adolescents

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

FEEDING CLINIC REFERRAL FORM

(to be completed by Pediatrician only)

Last Name: _____ First Name: _____

Date of Birth: _____ CR #: _____

Address: _____ City: _____

Postal Code: _____ Email: _____

Primary Diagnosis: _____ Medications: _____

Health Card #: _____ VC_____ HC# Expiry Date: _____

Parent/Guardian: _____ Home Phone #: _____

Weight: _____ **Length/Height:** _____

∗ **GROWTH CHART REQUIRED, please attach:**

Reason for Referral:

- ☐ **Child demonstrates oral-motor/ pharyngeal dysfunction affecting ability to meet Nutritional needs**
- ☐ **Child unable to move on to textured foods outside of normal developmental range**
- ☐ **Child having difficulty managing liquids**
- ☐ **Query / Increased risk of aspiration** (history of eating and breathing coordination problems, with ongoing respiratory issues).
- ☐ **Want to progress child from tube feeding**

Other:_____

_____

Investigations completed (Date): _____

Agencies Involved: _____

Developmental Concerns: _____

***Please note that Feeding Clinic is not able to provide service to children whose underlying feeding issues are behavioural in nature. For any inquires related to feeding referrals, please call the System Navigator at ext. 2074.**

PEDIATRICIAN: _____