Allied Health
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SYDNEY CHILDREN'S HOSPITAL

OUTPATIENT FEEDING CLINIC REFERRAL FORM

Referrer Details:

Date: _____ Referrer: _____

Phone: _____ Address: _____

****All referrals must be made by a medical officer e.g. GP or Paediatrician. Referrals can be made by a health professional if accompanied by a supporting referral letter from a medical officer. Please attach most recent consult letter or complete the details on page 2 of referral form****

Patient Details:

Name: _____ DOB:_____

Address: _____

Phone: _____ MRN: _____

Medicare No.: _____

Contact Person: _____

Bare weight: _____ (___ percentile) Length:_____ (___ percentile)

Date of measurement: _____

Please attach copies of growth charts

Reason for Referral:

To qualify for a feeding clinic appointment, the patient must have an area of concern in both growth & nutrition **AND** feeding skills. Difficulties in only one area will be referred to the relevant department. Tick all concerns that apply.

***Growth and Nutrition*:**

- ☐ Failure to Thrive *(as evident from recent heights and weights plotted on growth chart- please attach. NOTE: If <2 years, please use WHO growth charts)*
- ☐ Vitamin or mineral deficiency *(confirmed by blood test- please attach)*
- ☐ Enterally fed
- ☐ Low food intake

***Feeding Skills*:**

- ☐ Coughing/choking with feeds
- ☐ Frequent respiratory infections (? Aspiration)
- ☐ Lengthy feeding times/ Poor intake
- ☐ Poor transition to solids
- ☐ Difficulty with textures
- ☐ Stressful mealtime interactions
- ☐ Difficult mealtime behaviours

☐ The child is breastfeeding/ mother is expressing

****Please note: All information must be completed or supporting consult letter attached before the referral can be processed****

Medical History / diagnosis / birth history

Medications

Feeding History

Other concerns / issues