** REQUEST FOR PAEDIATRIC FEEDING SERVICES**

Upon receipt of the referral, the child will be directed to the appropriate feeding service within Simcoe County or York Region. **This form must be completed in order to process the referral**. **Incomplete referrals will be returned**. Referrals that are not appropriate for CTN services will be redirected to community providers/services, where possible, via CTN Access.

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| **Referral Date (dd-mmm-yyyy):** | **CTN Client Record # (if known):** | | | | **DOB (dd-mmm-yy):** | | | **GENDER:**  **M**  **F** | | |
| **Client’s Name (first name and surname):** | | | | | | **HCN:** **Version Code:** | | | | |
| **Client’s Address (include postal code):** | | | | | | | | | | |
| **Name of Family Physician:** | | | | **Parent(s)/Guardian/Client aware of this referral?**  **YES**  **NO** | | | | | | |
| **Name of Parent(s)/Guardian:** | | | | **Phone:**  **Phone:** | | | | | **H** **C** **W**  **H C W** | |
| **REFERRAL FOR:** | | | | | | | | | |
| Feeding Assessment and Consultation Team (FACS)\* **(Physician referral and growth charts are required)**  ***\*FACS team includes Registered Dietitian, Speech Language Pathologist and/or Occupational Therapist***  Dietitian Clinic (Simcoe only) **(Physician referral is required)**  Videofluoroscopic Swallow Study (VFSS) **(Physician referral and clinical feeding assessment required - if not available refer to FACS)**  Feeding MentorPreschool SLPPreschool OTSchool Age (Simcoe only) | | | | | | | | | |
| **Reason For Referral:** | | | | | | | | | |
| **Relevant Medical History/Pertinent Investigations and Consultations** (i.e. diagnosis, clinical note, recent bloodwork, previous feeding study results) **Attached Document(s),**  **See CTN Client Record OR**  **Additional Information (listed below):** | | | | | | | | | |
| **Current Feeding Status:**  **Oral**  **Tube** | | **Current Weight:** | | | | | **Current Height:** | | |
| **Medications or Supplements:** | | | **Allergies/Specialized Diet Information:** | | | | | | |
| **Others Involved In Child’s Care:** | | | **Additional Information/Other Developmental Concerns:** | | | | | | |
| Paediatrician:  Occupational Therapist:  Early Intervention:  GI/Nutrition/Feeding:  Speech Language Pathologist:  Other Specialists: | | | Behaviour  Speech and Language    Fine Motor  Gross Motor | | | | | | |
| **REFERRAL SOURCE INFORMATION:** | | | | | | | | | |
| **Name (please print):** | | | | **Phone Number:** | | | | | |
| **Designation:** | | | | **Fax Number:** | | | | | |
| **Signature:** | | | | **Date of Signature:** | | | | | |