** 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 Mentor**[ ]** Preschool SLP**[ ]** Preschool OT**[ ]** School 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:**  |