Children's Treatment Network
Building Brighter Futures Together

REQUEST FOR PAEDIATRIC FEEDING SERVICES

Fax to CTN ACCESS Intake at (705) 792-2775

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.

Referral Date (dd-mmm-yyyy):	**CTN Client Record # (if known):**	**DOB (dd-mmm-yy):**	**GENDER:** ☐ **M** ☐ **F** ☐ **Other**
Client's Name (first name and surname):		**HCN:** **Version Code:** **Diagnosis:**	
Client's Address (include postal code): **School:**			
Name of Family Physician:		**Parent(s)/Guardian/Client aware of this referral?** ☐ **YES** ☐ **NO**	
Name of caregiver (s): **Relationship to child:**		**Phone:** **Phone:**	☐ **#1** ☐ **Alt.** ☐ **#1** ☐ **Alt.**

REFERRAL FOR:

☐ Feeding Assessment and Consultation Team (FACS) assessment*
FACS team includes Registered Dietitian and/or Speech Language Pathologist and/or Occupational Therapist
☐ Dietitian Clinic*
☐ Videofluoroscopic Swallow Study (VFSS)* **(Clinical feeding assessment required - if not available refer for FACS Assessment)**

***Physician Referral Required.** **Please attach relevant reports and growth charts. Referrals must meet eligibility criteria which can be found at www.ctnsy.ca under programs and services.**

Feeding Mentor:
☐ Preschool SLP ☐ Preschool OT (Simcoe only) ☐ School Age OT (Simcoe only) ☐ School Age SLP (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 :	**Phone Number:**
Designation:	**Fax Number:**
Signature:	**Date of Signature:**

FAX COMPLETED REFERRAL FORM TO: CHILDREN'S TREATMENT NETWORK AT (705) 792-2775