****Child Health Service referral form****

**Feeding Clinic**

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| **\*Required field- Failure to complete required fields may result in referral being rejected** |

*Before making this referral, please consider/acknowledge the following:*

* *Please note, we do not accept referrals for overweight/obesity or eating disorders*
* *Children with eating disorders should be referred to NELFT Eating Disorder Service for Kent and Medway.*
* *Families requiring advice for weight management should be signposted to: Medway Council website for Weight Reducing and Simple Fussy eating advice. These pathways have been proven to be the most effective method of treatment.*
* *Infants with feeding difficulties should be referred to the Specialist Infant Feeding Team in the first instance, unless there are concerns regarding swallow safety, or significant concerns regarding weight gain and/or output (stool and urine output).*

**Consent**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| \*Are the parents/carers in agreement to this referral? |  |  |

|  |  |
| --- | --- |
| \*Referrer’s name |  |
| \*Referrer’s role |  |
| \*Referrer’s address |  |
| \*Referrer’s email address |  |
| \*Referrer’s phone number |  |

**General information**

|  |  |  |  |
| --- | --- | --- | --- |
| \*Date of referral |  | \*Child’s date of birth |  |
| \*Child’s first name |  | \*Child’s family or last name |  |
| \*Name child likes to be known by |  | NHS Number (if known) |  |
| \*Child’s ethnicity |  | \*Child’s home language(s) |  |
| \*Name of parent/carer/guardian with parental responsibility | |  | |
| \*Email of parent/carer for appointments, reports and information to be sent | |  | |
| \*Address where the child lives | |  | |
| \*Contact number for parent /carer | |  | |
| Name of second parent that has legal responsibility (if different from above) | |  | |
| Relationship to parent listed above | |  | |
| Email of second parent/carer for appointments, reports and information to be sent | |  | |
| Address of second parent/carer if different to listed above | |  | |
| Contact number of second parent/carer | |  | |
| \*Is interpreter needed? If yes, state language. | |  | |

**Who else works with the family or child?**

|  |  |
| --- | --- |
| \*GP’s name and address |  |
| Hospital doctor’s name and address |  |

**Services the family or child are already known to:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please check/tick all that apply | | Name (if known) | Please check/tick all that apply | | Name (if known) |
|  | Speech and language therapy |  |  | Dietitian |  |
|  | Occupational therapy |  |  | Learning disability nurses |  |
|  | Physiotherapy |  |  | Community nurses |  |
|  | Podiatry |  |  | School nurse |  |
|  | Health Visitor |  |  | Special needs nursery |  |
|  | Child and adolescent wellbeing service (NELFT) |  |  | Ophthalmologist |  |
|  | Audiology |  |  | Educational Psychology |  |
|  | Behaviour support |  |  | Early Help |  |
| Other – please state: | | | | | |

**School and Nursery Information (if applicable)**

|  |  |
| --- | --- |
| Name and address of school/nursery |  |
| Contact person name and email address |  |
| Contact number for school |  |

**Safeguarding**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Yes | No |
| \*Does the child have a child protection plan? | |  |  |
| \*Is the child a ‘child in need’? | |  |  |
| \*Is the child a ‘looked after child’? | |  |  |
| \*Has early help been initiated? | |  |  |
| Any further information regarding safeguarding |  | | |
| Social worker’s name and contact details |  | | |

**Medical History**

|  |  |
| --- | --- |
| \*Medical Diagnoses |  |
| \*Relevant Medical History |  |
| \*Current medications |  |
| \*Current acute services/professionals the infant/child is known to, with contact details (i.e., address/email) |  |

**Main/Presenting concern, and input sought from MCH Feeding Clinic services…**

|  |
| --- |
|  |

**Pathway specific questions**

|  |  |  |
| --- | --- | --- |
| **Concern** | **Tick the box of the concern that applies** | **\*Evidence/information/comments/ details corresponding to each of the concerns that apply.** |
| Feeding tube plus oral feeding.  *Please attach/detail current feeding regime.* |  |  |
| Feeding Tube and Non- Oral feeding/ NBM.  *Please attach/detail current feeding regime.* |  |  |
| Faltering Growth  *This is a drop of 2 centiles or more in weight+/-length* |  |  |
| Restricted range of foods  *Please specify extent of restriction and/or any missing whole food groups* |  |  |
| Poor appetite  *Please specify if this is because of acute or chronic illness or medication* |  |  |
| Suspected or diagnosed food allergies.  *Please specify foods and/or symptoms.* |  |  |
| Gastrointestinal (GI) symptoms e.g., reflux, constipation, diarrhoea |  |  |
| Suck and Swallow Incoordination |  |  |
| Weak Suck |  |  |
| Breathing disruptions or apnoea during feeding |  |  |
| Recurrent coughing during feeds/feeding. |  |  |
| New onset of sustained feeding difficulty. |  |  |
| History of recurrent pneumonia/ lower respiratory tract infections confirmed not to be viral in causality. |  |  |
| Concerns for possible penetration/aspiration (things going down the ‘wrong way’: towards the lungs) during feeding.  *For example:*   * *Breathing difficulties when feeding.* * *Coughing and/or choking during or up to a short while after swallowing.* * *Difficulty initiating swallowing.* * *Disengagement/refusal shown by facial grimacing, facial flushing, finger splaying, or head turning away from food source.* * *Frequent lower respiratory tract infections (not viral in nature).* * *Noisy or wet vocal quality during and after eating/drinking.* |  |  |
| Lethargy or decreased arousal during feeds. |  |  |
| Feeding period for longer than 30 to 40 minutes, resulting from functional feeding difficulties. |  |  |
| Nasopharyngeal reflux with feeding (food or drink entering or coming out of the nose) |  |  |
| Delayed feeding milestones due to functional feeding difficulties / difficulty managing age-appropriate textures/consistencies due to impairment of functional skill. |  |  |
| Craniofacial abnormalities and associated feeding/swallowing difficulties |  |  |
| Unable to sit independently, or difficulties independently maintaining a stable position for feeding.  *Please state what seating your child has for feeding/ or how they are positioned for feeding.* |  |  |