

HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL
FEEDING ASSESSMENT CLINIC
 Pre-Assessment Information form
Health Professional

Patient Information:

Name	Sex: M F	DOB:	Age:
Address			
Daytime Phone #			
Health Card # (+ Version Code)		Holland Bloorview Chart #	
Weight:		Height/Length:	

Name of Referring Health Professional: _____

Referring Physician #: _____ Phone #: _____

Date of Referral: _____

Reason for Referral: _____

Is this Referral for a **Second Opinion?** **Yes** **No**

Current Therapies:

- Speech O.T. Physiotherapy Dietician Psychology

Medical Diagnoses:*

- | | | |
|--|--|---|
| <input type="checkbox"/> CP: | <input type="checkbox"/> CNS trauma | <input type="checkbox"/> Hearing impaired |
| <input type="checkbox"/> athetoid | <input type="checkbox"/> head injury | <input type="checkbox"/> Neuromuscular |
| <input type="checkbox"/> ataxic | <input type="checkbox"/> C.V.A. | <input type="checkbox"/> Prematurity |
| <input type="checkbox"/> spastic | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> quadricplegic | <input type="checkbox"/> FTT | <input type="checkbox"/> Structural |
| <input type="checkbox"/> diplegic | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Visual impaired |

Other:

* Please note if the sole diagnosis is autism/PDD without suspicion of aspiration, then referral should be made to the NYG Autism Nutrition Clinic (Branson site) @ 416-632-8703

Has the child ever had any chest problems of any kind? Yes No

If yes, what problems and when? _____

Comments: _____

Method of Feeding:

Self feeder Fed by care giver

Formula (what type): _____

Comments: _____

Liquids: Tube
 Bottle
 Cup
 Other:

Non-liquids: Tube PO

Comments: _____

Purees: Yes No

Textured: Yes No

Solids: Yes No

Concerns about this patient's feeding:

- 1)
- 2)
- 3)

Medications: _____

Investigations to date (re: feeding disorders. (Please attach report copies!!)

<input type="checkbox"/> Barium swallow	Date: _____	Comments: _____
<input type="checkbox"/> Upper GI	Date: _____	_____
<input type="checkbox"/> Feeding Study	Date: _____	_____
<input type="checkbox"/> CXR	Date: _____	_____
<input type="checkbox"/> Other:	Date: _____	_____

Comments: _____

Would you as the Referring Health Professional like to attend the assessment?

Yes No

Please include copies of any results of investigations pertinent to the patient's feeding disorder, including all copies of any feeding studies.

If you have any questions, please call Ms. Amy Loong at 1-877-666-3823 or 416-424-3823.

PLEASE FILL OUT THIS FORM AND RETURN IT AS SOON AS POSSIBLE TO:

**Client Appointment Services
Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road,
Toronto, ON. M4G 1R8**

Fax: 416-422-7036

Revised: June 16, 2010