

FEEDING ASSESSMENT CLINIC

HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL

Feeding Assessment Clinic : Pre-Assessment Information Form

This form **MUST** be completed and returned **BEFORE** an appointment will be booked for your child

DATE COMPLETED: _____ COMPLETED BY: _____

Child's Name _____

Sex: Male Female

Date of Birth _____
Day Month Year

Diagnosis/Medical Concerns

What problem(s) is your child having when feeding/eating?

What do you hope to learn from this assessment?

MEDICAL HISTORY

Is your child taking any medications? Yes____ No____. If yes, please list.

Has your child ever had any of the following: Yes ✓

	Yes ✓	Date (s)
• Pneumonia,	_____	_____
• Frequent chest infections,	_____	_____
• Colds,	_____	_____
• Asthma,	_____	_____
• Bronchitis	_____	_____

FEEDING AND SWALLOWING INFORMATION

How does your child eat?

By mouth ___ By tube ___ Fed by others ___ Feeds Self ___

Type of tube _____ When was tube inserted _____

If tube fed, formula type and feeding schedule _____

What foods does your child eat? Please check:	<input checked="" type="checkbox"/>	Do you prepare this food in any special way (e.g. cut up small, thicken liquid)
Thin Liquids (e.g. water, juice, milk)		
Smooth Purees (e.g. yogurt, pudding)		
Textured/Lumpy Puree (e.g. oatmeal, stage 3/toddler baby food)		
Soft Solids (e.g. scrambled eggs, meatballs)		
Harder Solids (e.g. raw vegetables, chicken, steak)		

Please check if any of these apply to your child?

- | | |
|--|---|
| <input type="checkbox"/> Choking During a Meal | <input type="checkbox"/> Gagging during a Meal |
| <input type="checkbox"/> Food or liquid coming out of nose | <input type="checkbox"/> Eats Too much |
| <input type="checkbox"/> Spitting food out | <input type="checkbox"/> Eats too little |
| <input type="checkbox"/> Trouble Breathing during feeding | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Falling asleep during feeding | <input type="checkbox"/> Reflux/ vomiting during/after meal |
| <input type="checkbox"/> Postural Changes during feeding (stiffening) | <input type="checkbox"/> Refusal of oral feeding |
| <input type="checkbox"/> Noisy Breathing before, during or after feeding | |

How long does your child take to eat a meal? _____

POSITIONING

How does your child usually eat? Sitting Upright ___ Reclined ___ Lying Flat ___

Please check which seat your child uses to eat:

- | | | |
|----------------|-----------------------------|--------------------------|
| Lap ___ | Car seat ___ | Booster Seat ___ |
| High Chair ___ | Child's chair and table ___ | Wheelchair ___ Other ___ |

Does your child have difficulty in this position? Yes _____ No _____

CURRENT FEEDING AND SWALLOWING ASSESSMENT/THERAPY

Has your child received help for feeding at any of the following centres?

	Please check ✓	What advice or suggestions were you given?
Holland Bloorview	_____	_____
Hospital for Sick Children	_____	_____
Other _____		

CURRENT AGENCIES/THERAPISTS INVOLVED

Please list agencies/workers/therapists that are currently working with your child or helping you (Surrey Place, CCAC, Infant Development, Schools, Hospitals, Preschool Speech and Language, Geneva Centre etc.)

Agency	Worker/Therapist Name and Title
Example: Community Care Access Centre (CCAC)	Example: Occupational Therapist, Registered Dietician

Please return this form to the address below. Thank you for your prompt reply.

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

Fax: 416- 422-7036

Revised: December 2010