

## Feeding Assessment Clinic: Pre-Assessment Information Form

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

COMPLETED BY:

DATE COMPLETED:

Child's Name:

Sex: Male

Female

Other

Date of Birth:

(Day/Month/Year)

Preferred Phone Number:

Medical Record Number (if known):

Does your child have any known or suspected diagnoses or medical concerns?

YES (Please list)

NO, my child has no other medical or developmental concerns

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

What do you hope to learn from attending this feeding assessment?

Is your child taking any medications?    NO    YES (Please list):

Has your child had any of these respiratory/breathing issues? If yes, please include the dates

	NO	YES	Dates
Pneumonia			
Frequent chest/lung infections			
Colds needing antibiotics			
Bronchitis			
Asthma			

Does your child tend to have frequent fevers with no other signs of illness?

NO

YES

**How does your child eat/drink?**

All food and liquid is taken by mouth

Food and liquid is taken both by mouth and by tube (please indicate type of tube and date inserted)

All food and liquid is taken by feeding tube (please indicate type of tube and date inserted)

G-tube

Gj-tube

Ng-tube

**Please indicate your child's current ability to self-feed:**

My child is completely fed by others

My child can eat and drink independently

My child can eat and drink independently but prefers to be fed by others

My child participates in self-feeding however still needs some help

**Please use the chart below to indicate which foods and liquids your child is currently accepting and describe any special way you prepare the foods or liquids**

	NO	YES	Do you prepare the food in any special way? (cut up small, thicken liquid etc.)
<b>Thin liquid</b> (water, juice, milk)			
<b>Thickened liquid</b> (nectar juices, smoothies, yogurt drinks)			
<b>Thin purees</b> (yogurt, baby food pouches, applesauce)			
<b>Thick purees</b> (mashed potatoes)			
<b>Textured purees</b> (oatmeal, stage 3 baby foods)			
<b>Soft solids</b> (scrambled egg, meatballs)			
<b>Hard solids</b> (raw vegetables, steak)			

**Please indicate whether any of the below concerns apply to your child:**

Coughing or choking while eating or drinking

Noisy breathing before, during or after feeding

Difficulty breathing during feeding

Gagging during feeding

Reflux/vomiting during or after feeding

Postural Changes during feeding (arching, stiffening)

Food or liquid coming out of nose Spitting food out

Refusal of oral feeding

Swallowing food whole or before it is fully chewed

Holding or pocketing food in the mouth

**How long does your child take to finish a typical meal?**

**Please check the positions in which your child would normally eat and drink:**

- Sitting Upright
- Reclined
- Lying Flat
- Walking around

**Does your child have difficulty with positioning during feeding?**

YES      NO

**Has your child received help for feeding/swallowing at any of the following centres? If yes, please describe recommendations given:**

- Holland Bloorview
- Sick Kids
- Other

**Please list agencies/workers/therapists that are currently working with your child or helping you:**

<b>Agency</b> (Surrey Place, LHIN, Infant Development, Schools, Hospitals, Early Abilities, Geneva Centre etc.)	<b>Worker/Therapist Name and Title</b> Example: Occupational Therapist, Registered Dietitian

If you have any questions, please contact the Clinic Coordinator at 416-425-6220 ext. 3835.

Your referral will be processed when this completed form has been received. Thank you for your prompt reply.

Please fax or return this form to the address below. For privacy reasons, we do not recommend that you send this by email.

**Client Appointment Services**  
**Holland Bloorview Kids Rehabilitation Hospital**  
**150 Kilgour Road, Toronto, ON.**  
**M4G 1R8**  
**Fax: 416- 422-7036**