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**

COMPLETED BY:_____ **DATE COMPLETED:**_____
Child's Name (last, first):_____ **Sex: Male** ☐ **Female** ☐ **Other** ☐
Date of Birth: _____ (Day/Month/Year)
Preferred Phone Number: _____ **Medical Record Number (if known):**_____
Health Card Number: _____

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**

* R E F O U T P *

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.)
Thin liquid (water, juice, milk)	☐	☐	
Thickened liquid (nectar juices, smoothies, yogurt drinks)	☐	☐	
Thin purees (yogurt, baby food pouches, applesauce)	☐	☐	
Thick purees (mashed potatoes)	☐	☐	
Textured purees (oatmeal, stage 3 baby foods)	☐	☐	
Soft solids (scrambled egg, meatballs)	☐	☐	
Hard solids (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:

Agency (Surrey Place, LHIN, Infant Development, Schools, Hospitals, Early Abilities, Geneva Centre etc.)	**Worker/Therapist Name and Title** 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
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Revised: December 2018