**Eileen Lecky Clinic Reception contact number:** 020 8544 6101

**Wandsworth Multi-Disciplinary Feeding Service Referral Form**

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 **Wandsworth Paediatric Dietetics Referral Form (0-18 years)**

***The Wandsworth Multi-Disciplinary Feeding Service supports children who are* *highly selective eaters due to sensory sensitivities and/or behavioural differences.***

***A Parent Workshop will be offered as the entry point to the service for caregiver education.***

**Please send referrals via e-mail:** mdtfeeding@stgeorges.nhs.uk

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| **Date of referral:**  |  | **\*Incomplete referrals may not be accepted\*** |
| **Patient details:** | **GP details:** |
| Family name |  | Name and address of GP practice(Referrals require a Wandsworth GP) |  |
| First name |  |
| Date of birth(Only children 0-11 years are eligible) |  |
| NHS number |  | Name of GP |  |
| Gender assigned at birth  | [ ]  Male [ ]  Female | Telephone number |  |
| Name of parent / guardian |  | **School/Nursery:**(Children in specialist provisions are not eligible) |  |
| Mobile number |  | **Referrer details**: |
| Email address |  | Name |  |
| Home address |  | Profession |  |
| Base |  |
| Phone Number  |  |
| Is an **interpreter** required? Is **written information** accessible? | [ ] Yes [ ]  No **If yes**, please detail:[ ] Yes [ ]  No |
| Has this referral been **agreed** with the child’s parent/guardian? | [ ] Yes [ ]  No**Consent for referral and readiness/agreement to engage with the service must be obtained from parents** |
| Is the child subject to a **Child Protection Plan?**   | [ ] Yes [ ]  NoNamed **Social Worker**: |
| How is the child **currently feeding?** | [ ] Oral [ ]  Nasogastric (NG) tube [ ] PEG [ ]  Combination oral/enteral feeding |
| Any known **allergies?** | [ ] Yes [ ]  No**If yes**, please detail: |
| Are there concerns about the **child’s weight?**   | [ ] Yes [ ]  No**If yes**, Weight/height **centiles** - *at birth*: Weight/height **centiles** – *in last month*: |
| Does the child have any **significant medical history**, or formal diagnoses? |
| Please detail – *e.g. prematurity; diagnosed with Autistic Spectrum Disorder; on MDA pathway for diagnosis; frequent chest infections* |

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| Please tick the relevant **feeding difficulties for this child** from the list below: |
| [ ]  **Child eating fewer than 20 different foods** | [ ]  Child struggles to eat a range of textures |
| [ ]  Sensory difficulties impacting on feeding | [ ]  Child and/or parents finding feeding stressful |
| [ ]  Family mealtimes are significantly impacted | [ ]  Foods lost from diet cannot be reintroduced  |
| [ ]  Concerns regarding faltering growth/ weight loss  | [ ]  Physical / oral difficulties with feeding |
| [ ]  Missing entire food group(s): [ ]  Carbohydrates [ ]  Fruits and Vegetables [ ]  Dairy [ ]  Proteins |
| [ ]  Risk of, or overt aspiration/coughing during feeds | [ ]  Poor chest health/recurrent chest infections |
| **Further details,** and **other services** involved**?** |
| What has been **suggested, tried, and/or successful**? |
| **Additional information:** |
| **Signed:** | **Name:****Role:** | **Date:** |

**FOR CONCERNS REGARDING SWALLOWING DIFFICULTIES OR SIGNS OF ASPIRATION WHEN FEEDING PLEASE REFER TO THE COMMUNITY PAEDIATRIC DYSPHAGIA SERVICE.**

Signs of aspiration are as follows:

* History of chest infections
* Poor weight gain
* Coughing and/or choking during or after feeding
* Eye watering and/or blinking while feeding
* Wet/bubbly sounding breathing or voice during or after eating/drinking
* Excessive sweating while feeding
* Change to facial colour while feeding