**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  No  Named **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