**Direct Line:** 020 8544 6101

**Community Paediatric Dysphagia Service Referral Form**

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

*The Community Paediatric Dysphagia Service in Wandsworth support children who have physical oro-motor and swallowing difficulties when eating and/or drinking.*

**Please send referrals via iClip or e-mail:** **CommunityPaediatric.DysphagiaService@stgeorges.nhs.uk**

**FOR CONCERNS REGARDING CHILDREN WHO ARE SELECTIVE/AVERSIVE/BEHAVIOURAL EATERS PLEASE REFER TO THE WANDSWORTH COMMUNITY MULTI-DISCIPLINARY FEEDING TEAM**

This might look like:

* Gagging on food
* Struggling to eat a range of textures.
* Food refusal or eating fewer than 20 different foods.
* Stressful mealtime environment (for child and adults)
* Concerns with nutrition

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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, additional commissioning can be sought for over 12s if clinically indicated) |  |
| NHS number |  | Name of GP |  |
| Gender assigned at birth  | [ ]  Male [ ]  Female | Telephone number |  |
| Name of parent / guardian |  | **School/Nursery:** |  |
| Mobile number |  | **Referrer details** (if different to GP): |
| Email address |  | Name |  |
| Home address |  | Profession |  |
| Base |  |
| Phone Number  |  |
| 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 an **interpreter** required? Is **written information** accessible? | [ ] Yes [ ]  No **If yes**, please detail:[ ] Yes [ ]  No |
| Is the child subject to a **Child Protection Plan?**   | [ ] Yes [ ]  NoNamed **Social Worker**: |
| How is the child **currently feeding?** | [ ] Oral [ ]  NG/NJ tube [ ] PEG/PEJ [ ]  Combination oral/enteral  |
| 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 tick areas that apply:**[ ]  Prematurity[ ]  Neurological[ ]  ENT[ ]  Gastrointestinal[ ]  Cardiac[ ]  Respiratory[ ]  Genetic[ ]  Other | Please detail – *e.g. prematurity; frequent chest infections; Airway issues e.g. Laryngomalacia, GI tract issues* |
| Does the child take any **medications**? | Please list: |

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| Please tick the relevant **feeding difficulties for this child** from the list below: |
| UNDER 1s |
| [ ]  Overt coughing during feeds | [ ]  Choking episodes |
| [ ]  Poor chest health/respiratory concerns | [ ]  Risk of, or overt signs of, aspiration (see below) |
| [ ]  Physical / oral difficulties with feeding (e.g. weaning) | [ ]  Difficulties with latching to teat/nipple |
| [ ]  Feeds take more than 30 minutes | [ ]  Difficulties managing saliva |
| [ ]  Concerns about nutrition  | [ ]  Concerns about hydration |
| [ ]  Poor weight gain |  |
| OVER 1s |
| [ ]  Overt coughing during feeds | [ ]  Choking episodes |
| [ ]  Poor chest health/recurrent chest infections | [ ]  risk of, or overt signs of, aspiration (see below) |
| [ ]  Concerns with ability to chew / oral difficulties  | [ ]  Difficulties managing saliva |
| [ ]  Concerns about nutrition  | [ ]  Concerns about hydration |
| Signs of aspiration, please tick those that have been observed:[ ]  Coughing, choking and/or gagging during or after feeding[ ]  Eye watering and/or blinking while feeding[ ]  Wet/bubbly sounding breathing during or after eating/drinking[ ]  Rapid breathing or shortness of breath[ ]  Wet/gurgly sounding voice during or after eating/drinking[ ]  Excessive sweating while feeding[ ]  Change to facial colour while feeding |
| **If the child has had any chest infections in the last year please list and date:**Date: Required antibiotics? Yes/No |
| **Any other concerns not listed above?** |
| **Further details,** and **other services** involved**?**Is the child known to Portage? [ ] Yes [ ]  No**If yes**, please detail Portage worker: |
| What has been **suggested, tried, and/or successful**? |
| **Additional information:** |
| **Signed:** | **Name:****Role:** | **Date:** |