**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**](mailto:PaediatricCommunity.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  No  Named **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:** |