

\*\* Fax Completed Referral to 905-721-7774 \*\*

## Paediatric Feeding and Swallowing Clinic

The Feeding and Swallowing Clinic serves children and youth living in Durham Region, from birth to 17 years of age. This clinic accepts referrals for oral motor dysfunction resulting in poor weight gain, GERD and risk of aspiration. For a clinic visit, the child will be assessed by a team which may include a paediatric gastroenterologist, dietitian, occupational therapist and a speech language pathologist.

This clinic does **not** see patient for:

- Behaviour issues or mental health
- Parent/child interaction difficulties related to poor feeding/nutrition
- Sole purpose of nutrition/dietitian consultation or picky eaters

   refer to community dietitian or FCP

Order for a Video Fluoroscopic Swallow Study (VFSS) if indicated (check one):  $\square$  Yes  $\square$  No

Client Information:			
First Name:	Last Name:	D.O.B.	
Address:	City:	Province:	
Postal Code:	Phone:	Alternate:	
Health Card Number:			
Health Information:			
Medical Diagnosis:			
Primary concern regarding child's feeding:			
<ul> <li>□ Oral motor dysfunction resulting in poor weight gain</li> <li>□ Gastrointestinal concerns</li> <li>□ Swallowing difficulties, risk of aspiration</li> <li>□ Describe presenting problem:</li> </ul>			
Reason for Referral (referrals will be p	rioritized based on details provided -	please check all that apply)	
<ul> <li>□ Poor weight gain (FTT)</li> <li>□ Feeding refusal</li> <li>□ Poor transition to solids</li> <li>□ Reflux/vomiting</li> <li>□ Poor chewing skills</li> <li>□ Poor latch/suction impacting breast/bottle feeding</li> <li>□ Recent aspiration pneumonia</li> <li>□ Choking episodes</li> <li>□ Coughing or gurgly voice with eating/drinking</li> <li>□ Chronic respiratory problems</li> </ul>	<ul> <li>☐ Restricted diet (eating less than 10 foods)</li> <li>☐ Poor self–feeding skills</li> <li>☐ Pocketing food in mouth</li> <li>☐ Gagging</li> <li>☐ Chronic/recurrent abdominal pain or digestive issues</li> <li>☐ Tube wean with transition to oral solids</li> <li>☐ Nasal regurgitation</li> <li>☐ Takes a long time to eat</li> </ul>	<ul> <li>□ Picky eating</li> <li>□ Behaviour Challenges</li> <li>□ Nutrition concerns</li> <li>□ Tactile sensitivity</li> <li>□ Increased drooling/saliva production</li> </ul>	

DEE0069

REF0068 REVISED 16OCT2025

☐ Harmonized



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Name:	D.O.B.	Health Card Number:	
Attach Investigations already performed re: Feeding/Swallowing Concerns (labs, imaging, relevant consults, growth chart or previous hospital admissions)			
*Referral will be sent back without a growth chart attached*			
Other Professional Services Involved:			
☐ Grandview Kids ☐ Infant and Ch	ild Development ☐ Kinark	/ABA Services	
☐ Children's Development and Behavioura	•	e Services (RD, OT, SLP)	
Referral Information:			
Referring Physician Name:	Physic	cian's Signature:	
Address:	Phone	e:	
Billing Number:	Date:		