Complex Feeding and Nutrition Service
Division of Gastroenterology, Hepatology, and Nutrition
BC Children's Hospital
Room K4-190 • 4480 Oak Street
Vancouver, BC V6H 3V4
Phone: (604) 875-2345, local 7464

***** REFERRALS WILL NOT BE PROCESSED UNTIL COMPLETE *****

Referral date:

FAX COMPLETED REFERRALS TO **(778) 504-9764**
OR

CLIENT INFORMATION		
Surname:	First Name:	Preferred Name:
PHN:	DOB:	Gender:
Address:		Unit #:
City:	Province:	Postal code:
Home #:	Cell #:	Email:
Caregiver names:		
Spoken languages: ☐ English ☐ Other:		Interpreter required: ☐ Y ☐ N
Client and caregivers aware of the referral: ☐ Y ☐ N		
REFERRING PROVIDER		
Name:	Agency:	Billing #:
Office #:	Fax #:	Email:
Signature:		
If referring clinician is different from primary care provider:		
Name of primary care provider:	Primary care provider aware of the referral: ☐ Y ☐ N	
REASON FOR REFERRAL		
Referrals for a videofluoroscopic swallowing study **must** include a Radiology requisition		
MEDICAL HISTORY AND CONCERNS		
Birth history: ☐ Prematurity: weeks ☐ Pending / recent (< 3 months) NICU discharge		
Gastrointestinal symptoms: ☐ Vomiting / feeding intolerance		
Neuromotor delay: ☐ No ☐ Yes, mild to moderate / CP GMFCS level I, II or III ☐ Yes, severe / CP GMFCS level IV or V		
ASD: ☐ No ☐ Suspected, not yet diagnosed ☐ Yes, level: ☐1 (requires support) ☐ 2 (requires significant support) ☐ 3 (requires very significant support)		
ARFID: ☐ No ☐ Suspected, not yet diagnosed ☐ Yes, per diagnostic criteria relating to: ☐ Feeding and nutrition ☐ Psychosocial function		
Other / comments:		
ADDITIONAL INFORMATION OR CONCERNS		

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GROWTH *** REFERRALS WILL NOT BE PROCESSED WITHOUT UP-TO-DATE GROWTH CHARTS ***	
Weight ( ):	
Height/length ( ):	
☐ No growth concerns	☐ Severe malnutrition (WFL/BMI: ≤ -3 SD / ≤ 0th percentile)
☐ Decreased weight gain velocity	☐ Moderate malnutrition (WFL/BMI: -2 to -2.9 SD / 0th to 3rd perc)
☐ Weight loss	☐ Mild malnutrition (WFL/BMI: -1 to -1.9 SD / 4th to 15th perc)
☐ Recent (< 6 months) hospital admission for growth concerns / failure to thrive	
Other / comments:	

METHOD OF FEEDING	
Current feeding method(s): ☐ Oral ☐ NG tube ☐ G tube ☐ NJ tube ☐ GJ tube	
If child is tube feeding:	Do they have the potential to safely feed orally? ☐ Yes ☐ No
	Is weaning from tube feeds the goal of this referral? ☐ Yes ☐ No
	Describe their current feeding plan:
Other / comments:	

NUTRITION		
☐ Followed by local dietitian: Name: Contact:	☐ No nutrition concerns	☐ Poor appetite
	☐ Food group restrictions	☐ Refusal to eat
	☐ Food allergies	☐ Nutritional deficiencies
	☐ Dependence on oral supplements for weight gain	
Other / comments:		

ORAL-MOTOR AND SWALLOWING		
☐ Followed by local feeding support (feeding team, OT, SLP): Name: Contact:	☐ No oral-motor concerns	☐ No swallowing concerns
	☐ Gagging with meals	☐ Confirmed impaired swallow
	☐ Oral-motor difficulties	☐ Swallowing safety concerns
	☐ Oral aversion	☐ Choking with meals
	☐ Inappropriate texture for age	☐ Coughing with meals
		☐ Wet / gurgly voice with meals
		☐ Frequent respiratory illness
Other / comments:		

OTHER SUPPORTS	REFERRAL PENDING	ACTIVE	AWARE OF REFERRAL	NAME OR AGENCY
Community support (CDC, IDP, school)	☐ Date:	☐	☐	
Social worker	☐ Date:	☐	☐	
Other:	☐ Date:	☐	☐	