



**Child Development & Rehabilitation Center  
Pediatric Feeding & Swallowing Disorders Program**

Phone: (503) 494-8095, Fax: (503) 494-4447

Instructions: Please complete this referral form and fax to (503) 494-4447 along with **growth charts, progress notes, lab results, and any other pertinent information.** Thank you.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

PCP/Referring provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for referral/primary concern(s): \_\_\_\_\_

Please check box and *circle or underline specific concerns* related to feeding

- Oral motor concerns:** difficulty sucking / chewing / biting / manipulating food with tongue
- Swallowing concerns:** choking / gagging / food loss / suspected or known aspiration
- Sensory concerns:** difficulty seeing / touching / smelling / tasting food
- Growth and nutrition concerns:** failure to thrive / poor growth / weight loss / small stature / poor diet / adjust tube feedings
- Gastrointestinal concerns:** reflux / diarrhea / constipation / vomiting / retching
- Behavior/family/social concerns:** food refusal / tantrums / throwing food / difficult meal time environment
- Other:** \_\_\_\_\_

Other medical or neurodevelopmental problems (please mark all that apply)

- None
- Premature birth, if so weeks gestation \_\_\_\_\_
- Brain injury
- Seizures
- Developmental delays
- Birth defects (i.e. cleft palate)
- Autism spectrum
- Asthma/reactive airway disease/recurrent pneumonia
- Allergies (seasonal, food, medications)
- Vision or hearing problems
- Other medical, neurological or genetic conditions \_\_\_\_\_
- \_\_\_\_\_
- Current medications/vitamins \_\_\_\_\_
- Receiving therapy (physical, occupational, speech, feeding, other)

Referral priority: Routine (1-2 months)/Urgent (1-3 weeks)/Emergent (please call the clinic)

Other information that would be helpful to us: \_\_\_\_\_