Registered Office Address: Foirgneamh
Penny Ansley, Ascaill Vernon, Cluain Tarbh,
Baile Átha Cliath 3, D03 R973, Éire.
Penny Ansley Building, Vernon Avenue,
Clontarf, Dublin 3, D03 R973, Ireland.

Tel/Fon: +353 (0) 1 854 2200;
Fax/Facs: +353 (0) 1 833 5496
Email/Ríomhphost: info@crc.ie
Web: www.crc.ie

Complex Feeding Clinic - Referral form

This is a specialised service and the primary clinical responsibility will remain with the CDNT/PC Team.
Please ensure you complete the form fully to enable clinical decisions and prevent delays.

SECTION 1: Child/Young Person details	
Child/Young Person First Name	
Child/Young Person Surname	
Date of Birth	
CRC Number *(if applicable)*	
Address *(Please include eircode)*	
Parent or Guardian name(s)	
Home/Mobile Tel number	
Email	
Consent	Has the referring clinician gained verbal consent & discussed purpose of this referral with the child/parents/guardian? ☐ Yes ☐ No Reason
First Language	
Interpreter required?	☐ No ☐ Yes – the language required is
Special Supports / Circumstances	Please detail any additional supports e.g. social care, provided to this family / child that would be important for the team to be aware of.
GP Details	
Primary Care/CDNT Team ☐ Yes ☐ No	Please give details of local service below: Service Name: Address: Disciplines involved:

SECTION 2: Clinical details	
Reason for referral	1: 2: 3:

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Main medical diagnosis/es *e.g. all medical conditions including allergies, gastroesophageal reflux and any neurodevelopmental diagnosis/concerns*	
Investigations and input to date including assessments and interventions by local team	☐ Clinical swallowing assessment ☐ Feeding group ☐ Feeding clinic ☐ Videofluoroscopy ☐ Other (please detail)
Medications	Please list all known medications

SECTION 3: Summary of feeding/eating & drinking difficulties	
How is the child currently fed?	☐ Oral - Fully ☐ Enteral – NG / PEG / PEGJ / Other ☐ Mixed - Oral feeding with enteral ☐ Oral Supplements – please list: Please describe:
Current feeding/ eating & drinking concerns *e.g. SLT/parent/school.*	☐ Restricted diet ☐ range ☐ presentation ☐ textures ☐ Limited number of foods ☐ <5 ☐ <10 ☐ <20 ☐ Sensory skills e.g. difficulty touching/smelling foods ☐ Anxiety around food and mealtimes ☐ child ☐ carer ☐ Difficulty with behaviour with food and mealtimes ☐ Social communication disorder ☐ Difficulty chewing ☐ Difficulty progressing to age-appropriate textures ☐ Difficulty swallowing ☐ Other: _____ Please provide details:
Is weight or nutrition of concern?	☐ No ☐ Yes Weight: Centile: Date: Height: Centile: Date:

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Is hydration of concern?	☐ No ☐ Yes
Recent Blood test	Date: Results:
Previous therapeutic intervention	☐ Speech and Language Therapy ☐ Dietetic input ☐ Occupational Therapy ☐ Psychology ☐ CAMHS ☐ Child group intervention e.g. messy play/fun with food groups ☐ Parent education – please specify type of education ☐ Other Please provide a summary of previous therapeutic intervention related to their feeding

SECTION 4: Local professionals and educators involved		
Profession	**Name and contact**	**Currently involved**
☐ Paediatrician		☐ Yes ☐ No
☐ Speech and Language Therapist		☐ Yes ☐ No
☐ Dietitian		☐ Yes ☐ No
☐ Occupational Therapist		☐ Yes ☐ No

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☐ Psychologist/CAMHS		☐ Yes ☐ No
☐ Physiotherapist		☐ Yes ☐ No
☐ Social Worker		☐ Yes ☐ No
☐ Public Health Nurse		☐ Yes ☐ No
☐ Other		☐ Yes ☐ No

Name of creche/preschool/school
Have you gained parental consent to contact school? ☐ Yes ☐ No
If Yes, name and contact details of appropriate person in school:
Additional comments

Referrers/Key worker contact details			
Signed		**Telephone**	
Name		**Address**	
Title			
Date		**Email**	

Please ensure this form is completed correctly to avoid delays

Please complete and return with any relevant reports to:
Complex Feeding Clinic Referrals, Medical Office, Central Remedial Clinic, Penny Annesley Building, Vernon Avenue, Clontarf East, Dublin 3, D03 R973 or email specialistreferrals@crc.ie