Central Remedial Feeding, Eating, Drinking, Swallowing Clinic Referral Form

AN LÁRCHLINIC FEABHAIS

Address: *Foirgneamh Penny Ansley, Ascaill Vernon, Cluain Tarbh, Baile Átha Cliath 3, D03 R973, Éire.*
Penny Ansley Memorial Building, Vernon Avenue, Clontarf, Dublin 3, D03 R973, Ireland.
Tel/Fon: +353 (0) 1 854 2200 Web: www.crc.ie

Please note incomplete referrals WILL NOT be processed. Please ensure consent from client/ family for referral prior to completing same. Oversight of implementation of the recommendations from the FEDS assessment is not within the remit of the CRC Specialist FEDS service. This lies with the referring agent and local service. The CRC Specialist FEDS service is available to collaborate with and provide support to the local teams in implementing recommendations.

CLIENT INFORMATION

Client's name:	**Date of Birth**: (DD/ MM/YYYY):
Gender: Male ☐ Female ☐ Other ☐	
Address:	**Eircode:**
Mobile Phone:	**Email(s)**:
Client lives with: Parents ☐ Mother ☐ Father ☐ Foster Family ☐ Legal Guardian ☐ Alone/Independently ☐	
Name(s) of caregivers:	
Language/s spoken at home:	**Interpreter required?** Yes ☐ No ☐

REASON FOR REFERRAL

Date of Referral:

Specific Referral Question(s):

Client/Carer's Primary Concerns/Goals:

MEDICAL INFORMATION

Diagnosis:

Medical Card Number:	**Allergies:**	
Current medication/s and doses:		
Wheelchair/Buggy user: Yes ☐ No ☐	**Current weight:**	**Current height:**

CURRENT METHODS OF NUTRITION AND FEEDING

Oral ☐ Part Oral ☐ Tube Feeding (additional information with referral required) ☐ NPO (nil by mouth) ☐

Previous FEDS assessment: Yes ☐ No ☐ If yes: Date of assessment:

Current IDDSI Levels: Diet: Fluids:

Strategies recommended:

Methods of feeding: Self feeding ☐ Requires assistance with set up only ☐ Full assistance required ☐

Utensils used:

Name of seating used for mealtimes:

Positioning issues: Yes ☐ No ☐ If yes please provide details:

Central Remedial Feeding, Eating, Drinking, Swallowing Clinic Referral Form

AN LÁRCHLINIC FEABHAIS

Address: ***Foirgneamh Penny Ansley, Ascaill Vernon, Cluain Tarbh, Baile Átha Cliath 3, D03 R973, Éire.***
Penny Ansley Memorial Building, Vernon Avenue, Clontarf, Dublin 3, D03 R973, Ireland.
Tel/Fon: +353 (0) 1 854 2200 Web: www.crc.ie

Do any of the following apply to the client: Hypertonia ☐ Hypotonia ☐ Dystonia ☐ Poor head control ☐

Delayed gross motor skills ☐ Reduced fine motor skills ☐

Are any of the following features present/relevant to this client?

Recent change in swallowing/ feeding ☐

Parental / Staff / Client concerns ☐

Weight loss/failure to thrive ☐
Loss of appetite ☐

Coughing or choking episodes ☐

Extended mealtimes (beyond 30 minutes) ☐

Reflux / gastrointestinal problems ☐

History of lower respiratory infections/pneumonia ☐

Gagging / sensory ☐ (R ☐ L ☐ bilateral ☐)

Food refusal ☐
Vomiting with meals ☐

Difficulties with certain foods and liquids ☐

Management of secretions (saliva control) ☐

Sensory preferences impacting on mealtimes*: for example, food texture, noise, smell of foods, busy environments*

Participation at mealtimes:

Additional Comments:

REFERRER'S AND TEAM INFORMATION: ***THIS INFORMATION IS ESSENTIAL AND REFERRAL CANNOT BE PROCESSED WITHOUT SAME***

Referring Clinician: (*Print Name*)

Service/Team:

Email address:	**Contact Number:**

Postal Address:

Name of Family G.P. *(Include contact details)*

Name and Address of client's primary therapy service:

Other professionals involved:

Name	**Discipline**	**Service**

PLEASE ATTACH A COPY OF ALL PERTINENT REPORTS e.g. Videofluoroscopy reports (if available)

Referrer's Signature:

Please return COMPLETE referral form to Postal: Speech and Language Therapy Department, Central Remedial Clinic, Vernon Avenue, Clontarf, Dublin, D03 R973 or ***Email:*** specialistreferrals@crc.ie