IWK Feeding Clinic – Referral Form
5850/5980 University Ave., 4th Floor Link
PO Box 9700, Halifax, NS, B3K 6R8
Phone: 902-470-8406 Fax: 902-470-8736

Please note: The IWK Feeding Clinic accepts referrals for pediatric patients from Physicians and Nurse Practitioners who actively follow their patients. The IWK Feeding Clinic does not include a Dietitian.

Referring Physician/Nurse Practitioner Information

Name: _____
Address:
_____
Phone: _____
Fax: _____

Date of Referral: _____

Patient Information

Name & pronouns: _____
Date of Birth: _____
Health Card #: _____
Address:
_____

Parent/Guardian
name(s) & pronoun(s): _____
Phone Number(s):
_____

If this family requires an interpreter, what is their preferred language? _____

Concerns related to feeding (please select all that apply and provide further details below):

☐ The child has a restricted diet and has excluded one or more food groups
☐ The child has trouble transitioning from liquids to purees or from purees to chewable solid food
☐ The child has significant behaviour at mealtimes
☐ The child has trouble managing certain textures and swallowing food down and/or chokes/gags
☐ The child exhibits anxiety around food or has experienced a choking/gagging episode that has resulted in a narrowed diet
☐ The child is currently tube fed and having difficulty transitioning to oral feeding
☐ It is suspected that the child aspirates on some or all textures of food/liquid (please complete Diagnostic Imaging requisition requesting a Videofluoroscopic Swallow Study)
☐ The child is exhibiting oral aversion (i.e. refusing a bottle, refusing spoon-feeding)

Description of feeding challenges and family's goals for feeding:

Past medical history:

Medications:

☐ **The patient's recent growth chart or growth measurements are attached with the referral**