COMPLEX FEEDING AND SWALLOWING CLINIC SCREENER

Client First Name:

Client Last Name:

Date of Birth:

EMHware #:

Address:

Date of Screener:

Informant:

School:

The child being referred (please check all that apply):

- Has been diagnosed with failure to thrive
- Has enteral nutrition (tube fed)
- Has ongoing choking or vomiting during meals
- Has poor weight gain (e.g. has crossed two percentiles on growth chart) not related to an eating disorder (query referral to CYMH)
- Has significant weight loss (e.g. has crossed two percentiles on growth chart) not related to an eating disorder (query referral to CYMH)

Does the child (please check all that apply):

- Eat less than 20 different foods
- Eat only one texture, colour, or temperature; may only eat one brand or preferred item
- Refuses to eat one or more entire food group (vegetables and fruit, grains, protein foods)

** Client must have two or more of the above concerns to be eligible for the Complex Feeding and Swallowing Clinic Problem Feeder pathway

** Families who express any of the above concerns or express concerns around picky eating should self-register for the Supporting Your Picky Eater workshop (**click here**)

If this is a referral from a third-party provider and the child is not yet a client of FIREFLY, please complete a General Referral Form (**click here**) and fax all documentation to FIREFLY's Centralized Intake at 1-866-470-1783 or by email to **intake@fireflynw.ca**