Pediatric Feeding Program

Dear Parent / Guardian,

Thank you for your interest in the Pediatric Feeding Program at Good Shepherd. In order to ensure your child receives the most comprehensive feeding evaluation, please gather the following information and return in the pre-addressed, enclosed envelope, email, or fax to **610-778-1090:**

- The attached **intake packet**.
- The child's **most recent medical evaluation / medical record, including growth charts**.
- The child's **most recent behavioral, educational and / or psychological evaluation(s), including copies of current IEP or IFSP (if applicable)**.
- Prescription for **OT/ST for a diagnosis code for a feeding or swallowing dysfunction and/or secondary diagnoses**

After all of the above information is received,
you will receive a phone call to schedule your child's appointment.

All Feeding evaluations are completed on Friday mornings with an occupational therapist and a speech therapist. The evaluation will last approximately 60 minutes and will include an interview with the parent(s) for background feeding history and observation of the child with both non-preferred and preferred foods.

Please bring your child's preferred and non-preferred foods with you to the evaluation.

Following your child's evaluation, the therapists will review their recommendations, which may include:

- **Outpatient services**
  - Returning for weekly therapy at one of Good Shepherd's several area locations
  - Returning for monthly feeding follow-ups
  - Returning for other therapy (i.e. occupational, physical, speech) evaluations
- **Inpatient services**
  - Admission to pediatric rehabilitation hospital unit in Bethlehem, PA
  - Comprehensive, intensive multidisciplinary hospital-based feeding treatment
  - Close monitoring by physician led medical team, including round the clock nursing and respiratory care
- Referral to Early Intervention program as appropriate
- Referral(s) to medical specialists for additional diagnostic information
- Implementing a feeding home exercise program without initiating ongoing treatment

If you have any questions or need assistance, please contact us at:

Good Shepherd Rehabilitation Hospital
Pediatric Outpatient Rehabilitation Feeding Program
Attn: Kathleen Fortier (kfortier@gsrh.org)
850 South Fifth Street
Allentown, PA 18103
Phone: 610-776-8398 / Fax: 610-778-1090

Good Shepherd Pediatric Feeding Program Intake Packet 2

Date Packet Completed:_____

CONTACT INFORMATION

Child's name: _____

Parent / Guardians' name(s): _____

Date of birth: _____

Address: _____

City, State, Zip: _____

Preferred telephone number: _____Alternate telephone number: _____

Email address: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance (if applicable): _____ ID#:_____

Please list name, address, and telephone number of the referral source (MD, therapist, etc.):

FEEDING CONCERNS

1. Has your child ever or does he / she currently display any of the following feeding concerns? Check all that apply:

_____ Arching
_____ Bloating
_____ Burping / hiccupping
_____ Choking / coughing
_____ Congestion
_____ Constipation
_____ Desire to eat then refusal
_____ Diarrhea
_____ Difficulty with chewing
_____ Excessive gas
_____ Gagging / retching
_____ Grazing throughout the day
_____ Gulping
_____ Holding food in mouth
_____ Hypersensitivity to foods
_____ Irritability (crying)
_____ Limited variety / volume of foods
_____ Not progressing to age appropriate foods
_____ Pain with swallowing
_____ Requiring distractions to eat
_____ Skipping meals
_____ Slow weight gain
_____ Spitting or expelling foods
_____ Spitting up
_____ Vomiting
_____ Watery eyes and / or runny nose
_____ Wet sounding voice
_____ Other: _____

2. Please describe any additional feeding concerns you may have:

3. Please describe all of the goals you have for your child in regards to feeding:

PART I. BIRTH HISTORY

1. My child was born at _____ weeks gestation. Did you receive prenatal care? Y / N

Birth method (circle one): Caesarian-section Vaginal delivery

2. Birth weight: _____ lbs. _____ ozs.

3. Did Mother experience any of the following complications during pregnancy, labor, or delivery? Check all that apply:

_____ Abnormal ultrasound
_____ Eclampsia / pre-eclampsia
_____ Gestational diabetes
_____ High fever
_____ Infection
_____ Lack of sufficient amniotic fluid
_____ Pre-term labor
_____ Other: _____

4. Did your child have any of the following complications at birth? Check all that apply:

_____ Apnea
_____ Feeding / growth issues
_____ GERD (reflux)
_____ Necrotizing enterocolitis
_____ Respiratory issues (intubation, oxygen, trach, ventilation, etc.)
_____ Stay in the NICU; if yes, how long? _____
_____ Tube feedings (G-tube, NG tube, etc.)
_____ Other: _____

PART II. MEDICAL INFORMATION

1. My child has been diagnosed with:

_____

Please check all that apply:

_____ Autism / PDD
_____ Chronic lung disease / pneumonia / respiratory issues
_____ Developmental delay
_____ Down Syndrome
_____ Esophagitis
_____ Failure to thrive / slow growth
_____ GERD (reflux)
_____ Hearing impairment / loss
_____ Heart problems
_____ Hernia problem
_____ Kidney / liver problems
_____ Neuromuscular problems (Cerebral Palsy)
_____ Sensory Impairments
_____ Short bowel / gut syndrome
_____ Visual impairment
_____ Gastrointestinal issues (stomach issues)
_____ Other: _____

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2. Current weight: _____ Current height: _____

If known, please provide a few past measurements for your child:

Date_____ weight_____ height_____
Date_____ weight_____ height_____
Date_____ weight_____ height_____

3. Current medications (please list below or attach separate list):

Medication name	Dose	Frequency

4. Does your child have any allergies to medications and / or food? Please list all and describe reaction:

5. Please list **ALL** significant past medical history (hospitalizations, seizures, significant illnesses, surgeries, etc.):

6. Has your child completed any of the following medical tests? Check all that apply and list date:

_____ CT / MRI
_____ Endoscopy
_____ Esophagram
_____ Milk-scan (gastric emptying)
_____ Modified Barium Swallow (MBS)
_____ pH (impedance) probe
_____ Upper GI
_____ Other: _____

7. How often does your child have a bowel movement? Please list any concerns, if applicable:

8. Please list **ALL** specialists (name, area of specialty, and contact information) who currently follow your child (developmental pediatrician, dietician, gastroenterologist, psychologist, etc.):

PART III. DEVELOPMENTAL INFORMATION

1. Please provide the following information regarding your child's developmental milestones:

Developmental milestones	Age when reached	Comments
Rolled		
Sat without help		
Crawled		
Walked alone		
Spoke first word		
Put 2-3 words together		
Scribbled with a crayon		

2. Is there anything that your child used to do that he / she can no longer do? Y / N

   If yes, please describe:

3. Is your child currently receiving any therapy (behavioral therapy, counseling, occupational therapy, physical therapy, speech therapy, etc)? Y / N

   If yes, please list type, location, and frequency:

4. Is your child currently attending daycare or school? Y / N

   If yes, please describe:

PART IV. FEEDING INFORMATION

A. Feeding History

1. How was or is your child fed as an infant? Check all that apply:

   _____ Bottle (please list formula and bottle / nipple type):
   _____ Breast
   _____ Tube feedings

   Did your child have any difficulties with breast or bottle feeding? Y / N

   If yes, please describe:

2. At what age were solid foods (baby food, soft table foods, etc.) introduced?

   Did your child have any difficulties with solid foods? Y / N

   If yes, please describe:

B. Current Feeding Information

1. Is your child currently receiving tube feedings? Y / N
(If N, please proceed to question 2). If Y, please answer the following:

A. Percentage of daily intake via tube -

B. Tube type (NG, GT, GJ) -

C. Formula type -

Please describe tube feeding schedule:

Bolus feeds (list scheduled times, amounts of formula given, and rate) -

Continuous feeds (list time run, total amount of formula given, and rate) –

2. Please check your child's current ability to eat the following food textures:

Texture	Eats easily	Eats with difficulty	Refuses	Never presented
Puree				
Mashed				
Chopped				
Soft				
Crunchy				

3. Please give a few examples of foods that your child will eat from each category:

Dairy -

Drinks and snacks -

Fruits -

Grains (breads, cereals) -

Proteins (beans, eggs, meats, peanut butter) -

Vegetables -

C. Feeding Environment and Routine

1. My child typically eats: _____ alone _____ with others. Please list all caregivers involved in eating with your child:

2. How do you know when your child is hungry?

3. Where does your child typically sit during mealtimes? Check all that apply:

_____ Booster seat
_____ Car seat
_____ Chair at table
_____ Child stands
_____ Child wanders
_____ Held by caretaker
_____ Highchair
_____ Infant seat
_____ Other: _____

4. In what location(s) does your child eat or drink? Check all that apply:

_____ Car
_____ Daycare
_____ Dining room
_____ In front of TV
_____ Kitchen
_____ Living room
_____ School
_____ Other: _____

5. Where and with whom does your child eat the best?

6. Who is present in mealtimes at home? Check all that apply:

_____ Daycare provider
_____ Father
_____ Grandparent
_____ Mother
_____ Sibling
_____ Teacher
_____ Therapist
_____ Other: _____

D. Current Feeding / Drinking Skills

1. My child accepts food / liquid from: _____spoon _____fork _____bottle _____cup.

Please specify the type of bottle / cup your child is currently using: _____

2. Please rate your child's ability to do the following:

	Beginning	Partially successful	Independent	Not applicable
Finger feed				
Use spoon				
Use fork				
Drink from cup				
Drink from straw				

E. Behaviors

1. Does your child display negative behaviors during mealtime? Y / N

2. How does your child respond when presented with a non-preferred food (tantrums, throws food on floor, verbally refuses, etc.)?

3. How often does your child display these behaviors?

_____ 1 time per day
_____ 2 – 3 times per week
_____ 1 time per meal
_____ Multiple times within a meal
_____ Other: _____

4. What is your reaction to these behaviors (bribe, ignore, re-direct, etc.)?

5. How does your child respond to your reaction (behaviors increase, calms, etc.)?

6. Are there any punishment or rewards used related to feeding?

F. Motivation to Eat

1. Does your child show any of the following signs while eating?
   a. Appetite_____
   b. Nausea _____
   c. Fatigue_____
   d. Discomfort_____
   Please explain any of the characteristics listed above

2. Does your child display hunger at any times before mealtimes? What does this look like?

G. Sociological Factors

1. Do you or your child feel any stress around feeding/mealtimes?

2. Are there any cultural considerations that are important to remember related to feeding?

3. Does your child or family have any dietary restrictions? If yes, please list below:

4. Is your child involved in mealtimes at school? If so, what do these snacks/meals at school look like?

PART V. SENSORY INTEGRATION

1. Does your child demonstrate any of the following reactions? Please select all that apply:

___Sensitive to touch
___Dislikes having fingernails cut
___Dislikes messy play (sand, mud, etc.)
___Dislikes having teeth brushed
___Avoids eating certain textures
___Drools
___Puts inedible objects in mouth
___Difficulty with hand strength
___Likes to run and crash
___Likes to swing / spin / twist
___Likes to jump
___Likes "bear hugs"
___Enjoys pushing/pulling heavy objects
___Difficulty with sitting
___Sensitive to smells
___Other: _____

2. Do you have any concerns regarding your child with the following?

____Vision Please explain: _____

____ Hearing Please explain: _____

____Respiration Please explain: _____

PART VI. FOOD LOG

Please record ALL foods AND liquids (and amounts) accepted on a typical day.

Time	Food / Liquid	Amount	Comments