Child Last Name: Child First Name: DOB: FOLDER:

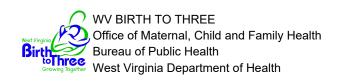
ID#:

1

MI

Date:

		Date of Screen	ing:
Child's Name:		DOB:	Age:
Parent/Caregiver:			
Address:		_ City:	Zip Code:
Phone: _	Em	nail:	
Name an	d Credentials of person completing screening:		
Please	check the correct answer or answers.		
1. Hov	w does your child eat? Check choices below that	best describe how.	
	Uses bottle Breastfeeds Takes sips from a cup Drinks from a cup with/without lid Uses a straw Takes oral feeding supplements (Pediasure®, Boost®, Kindercal®, and Neocate®) Has feeding tube you have any concerns or difficulty with any of the	Uses spe	poon Is with spoon/fork ecial feeding equipment, what? od other than milk from a bottle
2. Doe	es your baby enjoy eating? No Yes (li	^f no, please explain)	
3. Ho	w often are you feeding your baby? (more freque	ently than every 2 hou	ırs?) 🗌 No 🔲 Yes
4. Hov	w does your baby communicate that they are hun	gry? (typical/atypical)
5. Ho	w long does it take for your baby to eat? >30) minutes 🗌 <5 mi	inutes



Child Last Name:
Child First Name:

MI

DOB:
ID#:
FOLDER:
Date:

6.	Are you concerned about the amount or variety of foods your child takes in from the following groups? No See (If yes, check the foods that you have concerns about)				
	Milk and dairy foodsVegetablesBreads, cereals, rice, beans, and grains	Meat, eggs, fish, poultryFruitsFats			
	Snack foods (chips, soda, etc.)	☐ Sugar/sweet			
7.	Do you or your doctor have concerns about your chi	ld's size? ☐ No ☐ Yes			
	List the child's Length:	Weight:			
8.	Does your child have food allergies? No	Yes (If yes, list below)			
9.	Does your child take any medications or other suppl supplements) on a regular basis? No Ye				
10.	. Does your child experience any of the following?	☐ No ☐ Yes (<i>If yes, check all that apply</i>)			
	 □ Difficulty with sucking □ Difficulty with swallowing □ Difficulty with chewing □ Difficulty tolerating food textures □ Difficulty tolerating food temperature □ Choking □ Coughing 	 □ Diarrhea □ Constipation □ Vomiting/reflux □ Rashes □ Gagging □ Spitting out food □ Other: 			
11.	. Do you have concerns about your child's mealtime e	experiences and eating behaviors?			
	 No ☐ Yes (If yes, check all that apply) ☐ Child refuses to eat ☐ Child throws food or utensils ☐ Child eats too slowly ☐ Child stuffs mouth ☐ Child takes bottle to bed ☐ No scheduled mealtimes ☐ Meal times are hectic ☐ Meal seems to take too long ☐ Child unable to sit through meal ☐ Child does not eat enough at a meal 	 Child eats too much at a meal Child needs distractions in order to eat Child grazes Child needs to be positioned in a certain way to eat Child eats items, which are not food, (i.e. paint chips, crayons, dirt, paper, cigarettes, etc.) Other: 			

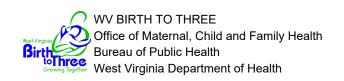
Child Last Name:	
Child First Name:	
DOB:	
FOLDER:	

MI

ID#: Date:

12. Has yo that ap	our child ever had a history or diagnosis of any opply)	of the follo	owing? No Yes (If yes, check all
□ A □ B □ C □ C	Aerodigestive disease Apraxia Autism Bronchopulmonary Dysplasia Cardiac Problems Cerebral Palsy Chronic constipation Chronic ear infections Cleft Lip or Cleft Palate		Motility issues Muscle disorders (MS, Spinal Muscular Atrophy) Myelomeningocele/Spina Bifida NAS/NOWS Neurological or Seizure Disorder Nutrition Support (tube or IV feedings, Other please specify:
	Congenital Heart Disease Cystic Fibrosis Diabetes Down Syndrome Failure to Thrive Fetal Alcohol Syndrome Gastrointestinal disorders Gastric emptying delay Genetic Disorder Hyperinsulinemia Lip/tongue/cheek tie Inborn Errors of Metabolism- Galactosemia, Glycogen storage disease, Phenylketonuria (PKU)		Pediatric feeding disorder Prader-Willi Syndrome Premature birth/Very low birth weight (VLBW) Pulmonary Disease Renal Disease Short Gut/Short Bowel Syndrome William's Syndrome Other, please specify:
14. What is No	u feel you have enough food/formula for your charges your level of concern about your child's eating of concern Somewhat concerned you like to meet with someone about your child or Yes	? Ver	No ☐Yes y concerned n or eating habits?
Question 2. Question 3. Question 4. Question 5. Question 6.	No (1) Yes (0) No (0) Yes (1) Typical (0) Not atypical (1) More than 30 minutes (1) less than 30 minutes (0) No (0) Yes (1)	Question 9 Question 1 Question 1 Question 1 Question 1	 3. No score 5. No score 6. No (0) Yes (1) Automatic referral 7. No (0) Yes (1) Automatic referral 8. No (0) Yes (1) 9. No score 9. Very concerned (2) Somewhat concerned (1) 9. No concern (0)

Total score possible is 12. Refer if the score is greater than 2 or if there are any concerns on questions 10 or 11.



Child Last Name:
Child First Name:
DOB: ID#:
FOLDER: Date:

MI

ACTIONS TAKEN:				
	Refer to services outside WVBTT (outpatient clinic, hospital, etc.) Refer to WVBTT SLP or OT for an assessment Share information with child's physician No further intervention needed Child is currently receiving feeding services from Parent requests IFSP team review			
***If child's fe promptly.	eding concerns are secondary to a sudden onset medical condition-refer to medical physician			