WV BIRTH TO THREE
Office of Maternal, Child and Family Health
Bureau of Public Health
West Virginia Department of Health

Child Last Name: _____
Child First Name: _____ MI _____
DOB: _____ ID#: _____
FOLDER: **E/A REPORTS** Date: _____

WV Birth to Three Feeding Screener

Date of Screening: _____

Child's Name: _____ DOB: _____ Age: _____

Parent/Caregiver: _____

Address: _____ City: _____ Zip Code: _____

Phone: _____ Email: _____

Name and Credentials of person completing screening:

_____

Please check the correct answer or answers.

1. How 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
- ☐ Finger feeds
- ☐ Fed by spoon
- ☐ Self-feeds with spoon/fork
- ☐ Uses special feeding equipment, what? _____
- ☐ Takes food other than milk from a bottle
- ☐ Other: _____

Do you have any concerns or difficulty with any of the above? ☐ No ☐ Yes *(If yes, please explain)*

2. Does your baby enjoy eating? ☐ No ☐ Yes *(If no, please explain)*

3. How often are you feeding your baby? (more frequently than every 2 hours?) ☐ No ☐ Yes

4. How does your baby communicate that they are hungry? (typical/atypical)

5. How long does it take for your baby to eat? ☐ >30 minutes ☐ <5 minutes ☐ 5-30 minutes

6. Are you concerned about the amount or variety of foods your child takes in from the following groups?

☐ No ☐ Yes *(If yes, check the foods that you have concerns about)*

- ☐ Milk and dairy foods
- ☐ Vegetables
- ☐ Breads, cereals, rice, beans, and grains
- ☐ Snack foods (chips, soda, etc.)
- ☐ Meat, eggs, fish, poultry
- ☐ Fruits
- ☐ Fats
- ☐ Sugar/sweet

7. Do you or your doctor have concerns about your child'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 supplements (vitamins, iron, fluoride, or herbal supplements) on a regular basis? ☐ No ☐ Yes (*If yes, list below*)

10. Does your child experience any of the following? ☐ No ☐ Yes (*If yes, check all that apply*)

- ☐ 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 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
- ☐ Mealtimes 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:

12. Has your child ever had a history or diagnosis of any of the following? ☐ No ☐ Yes (*If yes, check all that apply*)

- ☐ Aerodigestive disease
- ☐ Apraxia
- ☐ Autism
- ☐ Bronchopulmonary Dysplasia
- ☐ Cardiac Problems
- ☐ Cerebral Palsy
- ☐ Chronic constipation
- ☐ Chronic ear infections
- ☐ Cleft Lip or Cleft Palate
- ☐ 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)
- ☐ 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:
- ☐ 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:

13. Do you feel you have enough food/formula for your child? ☐No ☐Yes

14. What is your level of concern about your child's eating?
☐ No concern ☐ Somewhat concerned ☐ Very concerned

15. Would you like to meet with someone about your child's nutrition or eating habits?
☐ No ☐ Yes

Score key:

Question 1. No (0) Yes (1)
Question 2. No (1) Yes (0)
Question 3. No (0) Yes (1)
Question 4. Typical (0) Not atypical (1)
Question 5. More than 30 minutes (1) less than 30 minutes (0)
Question 6. No (0) Yes (1)
Question 7. No (0) Yes (1)
Question 8. No score
Question 9. No score
Question 10. No (0) Yes (1) Automatic referral
Question 11. No (0) Yes (1) Automatic referral
Question 12. No (0) Yes (1)
Question 13. No score
Question 14. Very concerned (2) Somewhat concerned (1) 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.

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 feeding concerns are secondary to a sudden onset medical condition-refer to medical physician promptly.