McMaster Children's Hospital

PLACE PATIENT
INFORMATION LABEL HERE

# PEDIATRIC GASTROENTEROLOGY FEEDING AND SWALLOWING TEAM (FAST) REFERRAL REQUEST

**REFERRING PROVIDER (NAME/FAX/SPECIALTY):**

**MAIN AERODIGESTIVE SAFETY CONCERN**:

- ☐ History of aspiration pneumonia
- ☐ Coughing/choking/respiratory changes associated with feeds
- ☐ Underlying diagnosis associated with aspiration
- ☐ Gastroesophageal reflux interfering with feeds (age <12 months)

**RELEVANT HISTORY (please attach relevant clinic notes):**

**PREVIOUS INVESTIGATIONS (please attach relevant blood work):**

| Investigation | Date(s) | Findings |
|---|---|---|
| Chest X-rays | | |
| Upper GI contrast study | | |
| Laryngoscopy/bronchoscopy | | |
| | | |

**PREVIOUS MANAGEMENT/TREATMENT:**

| Management/Treatment | Date(s) | Details (ie. name/location of clinician; dosages) |
|---|---|---|
| Community OT/SLP | | |
| Community RD | | |
| Medications | | |
| | | |

**REQUIRED INFORMATION:**

☐ **NEED FOR INTERPRETER? Circle YES or NO (IF YES; LANGUAGE: _____)**

☐ **GROWTH CHARTS ARE ATTACHED**

**ACCURATE COMPLETION OF THIS FORM WILL HELP TRIAGE YOUR PATIENT MOST EFFICIENTLY**

**FAX TO 905 521 2627**

UPDATED: March 25, 2021