

BARCODE



**MATERNAL, NEWBORN AND
PAEDIATRIC PROGRAM**
**Paediatric Feeding and Nutrition
Clinic Referral Form**

FORM PS330

REV 09/2023

Patient LABEL / Identification Area

Phone: 416-756-6410

Fax: 416-756-6547

Email: PFANclinic@nygh.on.ca

Please complete **all** sections of this form as incomplete forms will result in processing delays.

Family is aware of this referral: ☐ Yes (must be checked) Referral Date: _____ dd/mm/yyyy

CLIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____
DATE OF BIRTH: _____ dd/mm/yyyy ☐ Male ☐ Female
Is an interpreter required? ☐ Yes ☐ No Language Spoken: _____

PARENT(S) OR GUARDIAN

Parent/Guardian name: _____ Phone: _____ Cell/Alternate: _____
Parent/Guardian name: _____ Phone: _____ Cell/Alternate: _____
Address: _____
Province: _____ Postal Code: _____ Email: _____

REASON FOR REFERRAL (check all that applies)

- ☐ Any Neonatal Intensive Care Unit graduate who has:
☐ History of oral feeding difficulties
☐ Impaired oral intake that is not age appropriate
☐ Oral aversion
☐ Gastroesophageal reflux disease
☐ Any Paediatric Complex Care Clinic patient who requires additional feeding and nutrition support that is not being met by community Services.
☐ Any patient under 12 months previously seen in our Emergency Department, Paediatric Short Stay Unit and Paediatric Ambulatory Clinic And/or admitted to the Paediatric Unit with identified feeding concerns that require further assessment and intervention.
☐ Other (please contact team via email at PFANclinic@nygh.on.ca prior to making a referral).

SUPPORTING MEDICAL INFORMATION

Diagnosis: _____
Feeding and Medical History: _____
Medications: _____

*****For patients being referred from a community office, please attach a GROWTH CHART and any supporting documents (i.e. Feeding study results, lab work or imaging) with the completed referral form**

REFERRING PROFESSIONAL

Name: _____ Professional Designation: _____ Billing Number: _____
Institution/Agency: _____
Address: _____ Province: _____ Postal Code: _____
Phone: _____ Fax: _____ Email: _____

DATE	TIME (24 h)	SIGNATURE	PRINT NAME