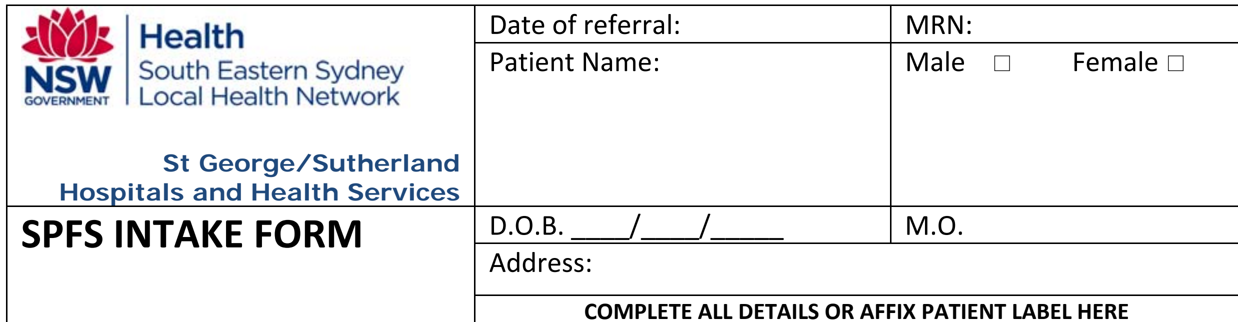
Speech Pathology Department
Level 1, Burt Neilson Wing
Gray St
KOGARAH NSW 2217
Ph: (02) 9113 1360
Fax: (02) 9113 1382

SPEECH PATHOLOGY FEEDING SERVICE (SPFS)– ST GEORGE HOSPITAL



Health South Eastern Sydney Local Health Network St George/Sutherland Hospitals and Health Services	Date of referral:	MRN:
	Patient Name:	Male ☐ Female ☐
SPFS INTAKE FORM	D.O.B. ____/____/_____	M.O.
	Address:	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Referrer Details

Name:	Profession:
Facility:	Contact No:
Postal Address:	

Patient / Client Details

Mother's Name & Surname :	Father's Name:
Home No:	Home No:
Mobile No:	Mobile No:
Address:	Address:
Preferred Language:	Interpreter required: Yes ☐ No ☐

GP Details	**Paediatrician Details**
GP Name:	Paediatrician Name:
Phone No:	Phone No:
Address:	Address:
Is GP aware of Referral ? Yes ☐ No ☐	Is Paediatrician aware of Referral? Yes ☐ No ☐

Diagnosis / Medical History: (Include any relevant details – co-morbidities, test results. Please attach any relevant reports)

Does child have a significant developmental delay or Autism Spectrum Disorder? Yes / No

Does the child have? ☐ Enhance Primary Care Plan Yes / No ☐ Better Start Funding Yes / No

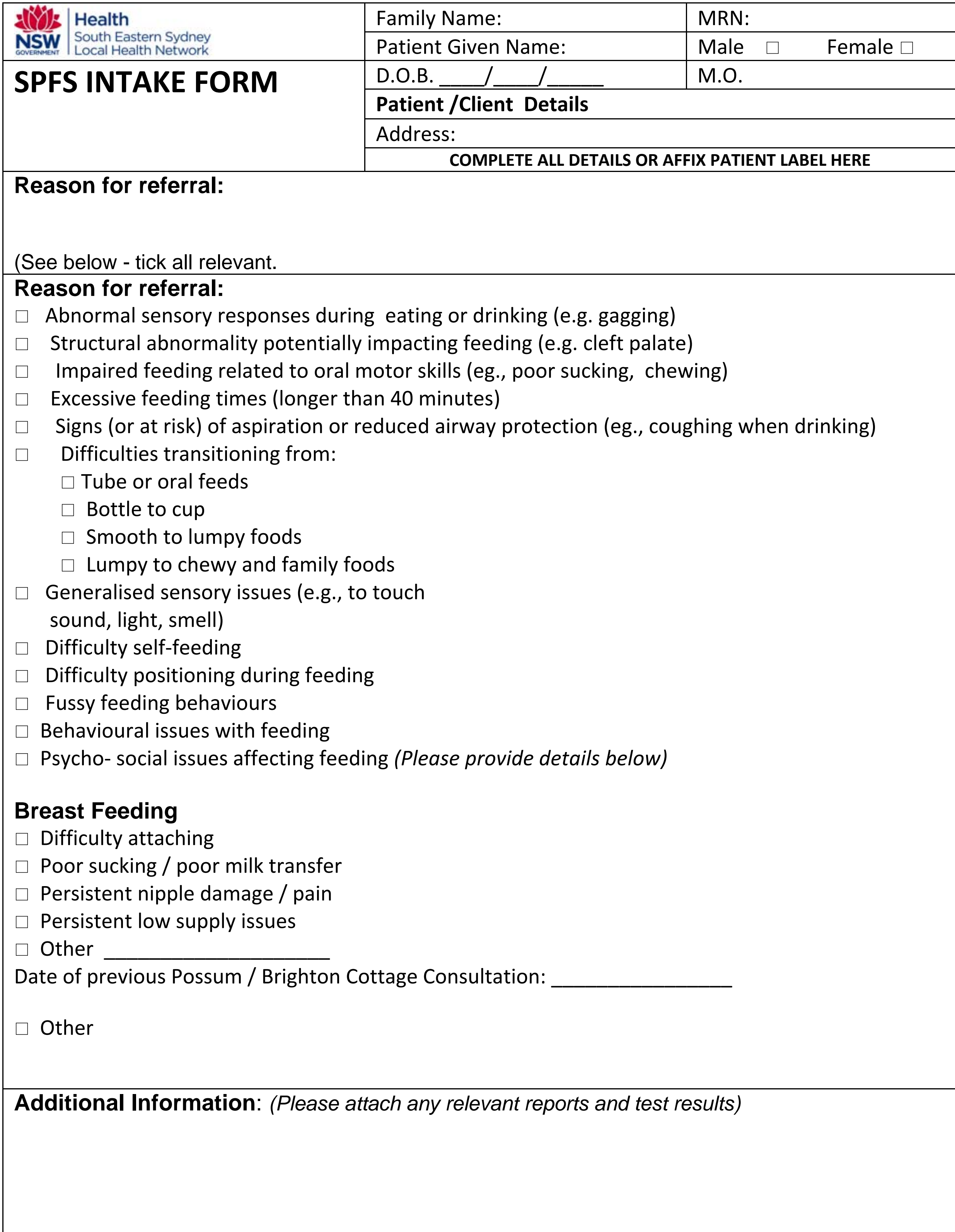
Other Referrals Made: (Include discipline, service and contact details):

Other Community Services / Private services already received:

☐ Possum / Brighton Cottage ☐ Tresillian ☐ Karitane ☐ Aging Disability and Home Care
☐ Developmental Assessment Service
☐ Child and Family Health Centre - Please Specify:
☐ Other (eg., Cerebral Palsy Alliance, Lifestart, Sydney Children's Hospital Services):

Allied Health

☐ Speech Pathology - Please Specify:
☐ Dietetics - Please Specify:
☐ Occupational Therapy - Please Specify:
☐ Social Work/ Psychology- Please Specify:



Health South Eastern Sydney Local Health Network NSW GOVERNMENT	Family Name:	MRN:
	Patient Given Name:	Male ☐ Female ☐
SPFS INTAKE FORM	D.O.B. ____/____/_____	M.O.
	Patient /Client Details	
	Address:	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Reason for referral:

(See below - tick all relevant.

Reason for referral:

☐ Abnormal sensory responses during eating or drinking (e.g. gagging)
☐ Structural abnormality potentially impacting feeding (e.g. cleft palate)
☐ Impaired feeding related to oral motor skills (eg., poor sucking, chewing)
☐ Excessive feeding times (longer than 40 minutes)
☐ Signs (or at risk) of aspiration or reduced airway protection (eg., coughing when drinking)
☐ Difficulties transitioning from:
- ☐ Tube or oral feeds
- ☐ Bottle to cup
- ☐ Smooth to lumpy foods
- ☐ Lumpy to chewy and family foods

☐ Generalised sensory issues (e.g., to touch sound, light, smell)
☐ Difficulty self-feeding
☐ Difficulty positioning during feeding
☐ Fussy feeding behaviours
☐ Behavioural issues with feeding
☐ Psycho- social issues affecting feeding *(Please provide details below)*

Breast Feeding

☐ Difficulty attaching
☐ Poor sucking / poor milk transfer
☐ Persistent nipple damage / pain
☐ Persistent low supply issues
☐ Other _____________________

Date of previous Possum / Brighton Cottage Consultation: _________________

☐ Other

Additional Information: *(Please attach any relevant reports and test results)*

Please Fax Referral to: Feeding Clinic 9113 1382 or
Post to: Feeding Clinic, Level 1, Burt Nielson Wing, Gray Street KOGARAH NSW 2217