



COMPLEX FEEDING AND SWALLOWING CLINIC SCREENER

Client First Name:

Client Last Name:

Date of Birth:

EMHware #:

Address:

Date of Screener:

Informant:

School:

The child being referred (please check all that apply):

Has been diagnosed with failure to thrive

Has enteral nutrition (tube fed)

Has ongoing choking or vomiting during meals

Has poor weight gain (e.g. has crossed two percentiles on growth chart) not related to an eating disorder (query referral to CYMH)

Has significant weight loss (e.g. has crossed two percentiles on growth chart) not related to an eating disorder (query referral to CYMH)

Does the child (please check all that apply):

Eat less than 20 different foods

Eat only one texture, colour, or temperature; may only eat one brand or preferred item

Refuses to eat one or more entire food group (vegetables and fruit, grains, protein foods)

**** Client must have two or more of the above concerns to be eligible for the Complex Feeding and Swallowing Clinic Problem Feeder pathway**

**** Families who express any of the above concerns or express concerns around picky eating should self-register for the Supporting Your Picky Eater workshop ([click here](#))**

If this is a referral from a third-party provider and the child is not yet a client of FIREFLY, please complete a General Referral Form ([click here](#)) and fax all documentation to FIREFLY's Centralized Intake at 1-866-470-1783 or by email to intake@fireflynw.ca