CRC Specialist Services
FEDS Referral Form

MEDICAL AND HSCP CAN REFER.
MUST BE COMPLETED IN FULL TO BE CONSIDERED.
PLEASE ATTACH RELEVENT RECENT REPORTS.
PLEASE ATTACH ANY RECENT/RELEVANT MEDICAL INFORMATION
MEDICAL REFERRAL REQUIRED FOR ALL ADULT FEDS REFERRALS

Oversight of implementation of the recommendations from the FEDS assessment **is not within the remit of the CRC Specialist FEDS service**. This lies with the referring agent and local service. The CRC Specialist FEDS service is available to collaborate with and provide support to the local teams in implementing recommendations.

Client's Name:		
Client's Address:		
Client's Contact Number:		
Client's DOB:		
Date Referral :		
Paediatrician/Rehab Consultant:		
CDNT:		
GP (name and contact details):		
Name and profession of referrer:		**Contact Number:**

Medical information:

Diagnosis:	Cerebral Palsy/ Neuromuscular/Spina Bifida Unknown /under investigation Other: _____
Medications	
Wheelchair user:	Yes/No
Balance/posture needs:	Yes/No
Sensory needs:	
Current weight and height:	
Other professionals involved:	

Local/Previous service for FEDS: Yes ☐ No ☐
Type of previous FEDS intervention: _____
Duration of FEDS intervention: _____
Previous VFSS: Yes ☐ No ☐ **Date of previous VFSS**: _____
Completed at: _____

Current methods of nutrition and feeding

Oral	
Part Oral	
Tube Feeding (please provide additional information with referral)	
NPO (nil by mouth)	

Methods of feeding:

Self feeds	
Requires assistance / dependence	
Positioning issues	

Reasons for referral/clinical need for referral:

Are any of the following features present/relevant to this client?:

Recent change in swallowing/ feeding	
History of lower respiratory infections/pneumonia	
Parental / Staff / Client concerns	
Gagging / sensory	
Weight loss/failure to thrive	

Food refusal	
Loss of appetite	
Vomiting with meals	
Coughing or choking episodes	
Difficulties with certain foods and liquids	
Extended mealtimes (beyond 30 minutes)	
Management of secretions (saliva control)	
Reflux / gastrointestinal problems	
Other	

Please outline the impact of FEDS on day to day function:

Consent of client / family / Legal guardian ☐ Yes ☐ No
Interpreter required? ☐ Yes ☐ No **Language Spoken:** _____
Anything pertinent to support client / family attending:

Comments:

Key contact for client on CDNT: _____
Contact details for key contact: _____
Will member of CDNT be able to attend the appointment?: Yes/No

Additional Comments:

Referrer Name / Profession / Signature:

_____

Please send to Speech and Language Therapy Dept. at Central Remedial Clinic, Penny Ansley Building, Vernon Ave, Clontarf East, Dublin, D03 R973 or by email to: specialistreferrals@crc.ie

FEDS TEAM USE ONLY AT REFERRALS MEETING:

Date Referral Received	
Date Referral Discussed	
Action	Appoint ☐ Reject ☐
Priority	High ☐ Moderate ☐ Low ☐
Team	

FEDS team keyworker: _____
Follow up:_____

Signed: