

Phone: 414.266.FEED (3333) • Fax: 414-266-4709

Thank you for your confidence to refer to the Feeding, Swallowing and Nutrition Center. Please fax this completed form along with pertinent records (clinic notes, test, labs or imaging results and consultations) and insurance referral authorizations to 414-266-4709. This information is required to start the intake process.

*The Center does not treat anorexia or bulimia.*

Patient Information	Referring Provider Information
Patient Name: _____	Provider Name: _____
Parent/Guardian Name(s): _____	Provider Address: _____
Patient Address: _____	Phone Number: _____
Date of Birth: _____	Fax Number: _____
Home Phone Number: _____	
Work Phone Number: _____	
Insurance Carrier: _____	

1. What is the patient's chief complaint? **MUST DESCRIBE.**

\_\_\_\_\_

\_\_\_\_\_

- At what age did the problem start? \_\_\_\_\_
- How long has the problem been going on? \_\_\_\_\_
- Has the child lost weight?  Yes  No If yes, for how long? \_\_\_\_\_
- Has the child not gained weight?  Yes  No If yes, for how long? \_\_\_\_\_
- How long do meals last?  10 mins  15 mins  30 mins  45 mins  60+ mins
- Are meal times stressful?  Yes  No
- Does the child receive tube feeds?  Yes  No
  - o Tube feeds only?  Yes  No
  - o Tube and oral feeds?  Yes  No
- Has the child had pneumonia or other respiratory problems within the last year?  Yes  No

2. Pertinent past medical history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referring Provider Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

OFFICE USE ONLY		
Date Received: _____	Clinic: _____	Clinician/MD: _____
<input type="checkbox"/> Referral Accepted Date of Appointment: _____		
<input type="checkbox"/> Referral Denied Reason: _____		
Referral status communicated to _____ on ____ / ____ / _____.		
Notes: _____		
_____		

APPLY DT BARCODE STICKER  
MD Referral Accepted DT 346  
MD Referral Denied DT 9901