Please bring a copy of this completed form with you to the Functional Feeding Evaluation.

Your child, ___________________________ is scheduled for a functional feeding evaluation at Arkansas Children’s Hospital on ____________ at____________. This appointment has been requested by your child’s doctor due to concerns for oral feeding skills. Please review the following information in preparation for your child’s feeding evaluation and complete the enclosed questionnaire and bring with you on the day of your appointment. If you are unable to keep this scheduled appointment, please contact us at (501) 364-4319 prior to your child’s scheduled appointment time.

Things you will need to bring with you for your child’s feeding evaluation with the Speech Pathology Department of Arkansas Children’s Hospital:

- _____Formula or other liquid that your child drinks or takes through his/her feeding tube
- _____Your child’s bottle or cup that he/she normally uses;
- _____2-3 of your child’s preferred foods, if your child is eating baby foods or solid foods
- _____2-3 foods that your child typically refuses, if your child is eating baby foods or solid foods
- _____Any special feeding utensils used by your child (specialty bottles/cups, special spoons, etc.)
- _____A pacifier or teether toy (if age appropriate for your child)
- _____One of your child’s favorite toys
- _____Your child’s toothbrush
- _____Copies of any prior evaluation reports

We also request the following to try to optimize the evaluation process:

- We would like for your child to be hungry when he/she arrives for the feeding evaluation. Try not to immediately feed your child 2 hours prior to the appointment or he/she may not be interested in eating at the evaluation.
- Make sure that your child gets appropriate rest prior to the evaluation.
- Please plan to be on time for your child’s scheduled evaluation. Allow approximately 30 minutes prior to your child’s scheduled appointment time to find appropriate parking, locate the registration area, and to complete the registration process.
- We look forward to meeting you and your child.

Please fill out the following questions and bring with you on the day of your child’s appointment.

- What is your main concern regarding your child’s feeding skills and what do you hope to gain from this evaluation? ____________________________________________________________

- If your child eats by mouth, what types of foods does your child typically eat for:
  breakfast _________________________________________________________________
  lunch ________________________________________________________________
  dinner _______________________________________________________________
  snacks ______________________________________________________________
  liquids ________________________________________________________________

- List any foods that your child refuses to eat: ________________________________

- List any medications that your child currently takes:
Describe your primary concern regarding your child's feeding skills:


Has your child ever had a swallow study?  ____yes  ____no
If yes, when, where, results:

Please check any of the following medical issues that have been a part of your child's history:

- reflux
- G-tube (bolus/continuous)
- ear infections/ear fluid
- tonsillectomy
- sleep apnea
- laryngomalacia
- RSV
- frequent wheezing
- seizures
- seasonal allergies
- medication allergies
- premature birth
- history of aspiration
- delayed skills for talking

Other

Please check any of the following related to your child's feeding history:

- difficulty with bottle feeding
- frequent changes in nipple
- spits up frequently after eating
- poor intake with bottle
- does not take baby foods
- difficulty chewing solids
- gags often with foods
- holds food in mouth for a long time
- eats solids but is very picky

Other

Thank you for taking the time to complete this information prior to your child's scheduled appointment. If you would like to mail or fax the info prior to the appointment please feel free to do so to the following:

Arkansas Children's Hospital
Speech Pathology Department
1 Children's Way, Slot 113
Little Rock, AR 72202
Fax # (501) 364-6659