Surveillance Sheet: Feeding Difficulties

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| Child’s Name |  | Completed by |  |
| D.O.B/Age |  | Job Title |  |
| NHS Number |  | Date |  |

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|  | **Notes / Examples** |
| **Early feeding history** | *(e.g. breast/bottle feeding, tongue tie, reflux, milk allergies)* |
| **How/when did you know your baby was ready for weaning?** | *(e.g. able to sit unsupported)* |
| **How did you start weaning your baby?** | *(e.g. positioning, equipment, environment, communication)* |
| **What food/textures does your baby enjoy?** |  |
| **What food/textures does your baby struggle with?** | *(and how do they communicate this?)* |
| **Is your baby gagging on certain foods?** | *(If yes, how do you respond?)* |
| **Does your child show distress at mealtimes?** | *(e.g. refusal, tantums, throwing food)* |
| **Is your child neophobic? (fearful of trying new/different foods)** |  |
| **Is your baby following their expected growth/height trajectory?** |  |
| **Is your baby showing signs of motor developmental delay?** | *(If yes, are feeding difficulties in-line with their developmental stage?)* |
| **Does your baby have issues with increased/decreased tone?** |  |
| **Are any signs of aspiration observed when the baby eats or drinks?** | *Select: Coughing, voice change, colour change, eye blinking/watering, change in breathing rate, fatigue, distress* |
| **Has there been any choking?** |  |
| **Has your baby had many lower respiratory chest infections?** | *(Provide dates if known)* |

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|  | **Prior to referral** |
| **What has been tried so far to help develop their feeding skills?** |  |
| **How concerned are you about your baby’s delayed feeding difficulties?** |  |
| **How long has your baby been struggling with feeding?** |  |

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| **CRITERIA FOR REFERRAL** | **CRITERIA FOR MONITORING** |
| REFER to feeding team if parent/carer reports:   * **Choking episodes** * **Unexplained chest infections** * **Signs of aspiration** * **Advice is not effective after 6 months and high level of parental concern** * **Failure to meet expected weight/height development – \* also refer to dietetics** * **Child has moderate-severe developmental delay e.g. more than 6m motor delay** * **Child has neurological diagnosis or syndrome and developmental delay** * **Issues with hypo/hypertonia that are suspected to be interfering with feeding** | **MONITOR** for 3-6 months if parent/carer reports:   * **No choking episodes** * **No history of unexplained chest infections** * **No signs of aspiration** * **Difficulties experienced for less than 6 months** * **Meeting expected weight/height development** * **Low level of parental anxiety** * **Feeding difficulties are in line with their developmental stage (not age)** * **Behavioural difficulties associated with mealtimes** * **Neophobic** |

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| **Action:** | **Refer to SLT** | Yes / No | **Monitor** | Yes / No | **Follow up in weeks / months** |  |