JUMBUNNA COMMUNITY PRESCHOOL AND EARLY INTERVENTION CENTRE INC.

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Mealtime Assessment Referral Form

Name:	DOB:
Room:	Days Attending:
Key Worker:	Date of referral:
Diagnosis:	Urgent/Non-urgent

Reason for referral, please tick the following:

- Coughing, choking, gagging or frequent throat clearing after or during swallowing
- Difficult painful chewing or swallowing
- Becoming short of breath when eating or drinking
- Having long mealtimes, eg more than 30mins
- Avoiding some foods because they are hard to swallow
- Regurgitation of undigested food
- Difficulty controlling food or liquid in their mouth, eg, losing food or drink from mouth
- Drooling
- Having a hoarse or gurgly voice during eating
- Poor oral hygiene, eg, pocketing food well after meal has finished
- Frequent heartburn, eg, complains of chest pain after meal
- Unexpected weight loss
- Frequent unexplained respiratory infections
- Difficulty sitting upright in the chair during mealtimes
- Other ____

Any additional Information:

Please place this referral in NDIS Coordinator referral tray or email.