MARSHALL UNIVERSITY FEEDING AND SWALLOWING CLINIC
INTAKE FORM

Name: _____ **Parent/Guardian Name**_____

Date of Birth: _____ **Age:** _____ **Address:** _____

County: _____ _____

Sex: _____ **Telephone:** _____

Referral Date: _____ **Date of Intake:** _____

Referral Source: _____ **Phone:** _____

Reason for Referral/Diagnoses: _____

_____

Primary Care Physician: _____

Parent concerns: _____

Gestational age/birth wt_____

Reflux/ears/asthma/upper respiratory_____

Feeding route/diet: food textures, beverages, formulas, vitamins_____

Current Wt-under/over/FTT_____

Medications/food allergies: _____

Gross motor/self-feeding: _____

Feeding/swallowing: _____

Previous evaluations or interventions: _____

Services currently receiving: _____

FAX TO 304-696-2986 ATTENTION: Pam Holland

FOR OFFICE STAF ONLY:

Case history out _____

Case history received _____

Information packet out _____

Evaluation Scheduled _____