MARSHALL UNIVERSITY SPEECH AND HEARING CENTER
FEEDING AND SWALLOWING CLINIC
1 John Marshall Drive
Smith Hall 143
Huntington, WV 25755
(304)-696-2985
Fax: (304) 696-2986

REQUEST FOR MEDICAL INFORMATION

Your patient, ____________ has requested an appointment with the Marshall University Feeding and Swallowing Clinic which is scheduled for ___________. In an effort to provide collaborative care, all patients are asked to contact their primary care physician/pediatrician to obtain the following information.

CHILD'S NAME: ________________________________

DOB: ____

ADDRESS_____________________________________

____

____

PHONE_______________________________________

____

CHILD'S DIAGNOSES:

____

____

____

CURRENT MEDICATIONS:

____

____

____

FEEDING PROBLEM/REASON FOR REFERRAL:

____

____

____

____

____

PHYSICIAN NAME/ADDRESS/PHONE:

____

____

____

Any contraindications to putting this child through a trial feeding with solids and/or liquids?

____

____

____

____

____

Any contraindications to using behavioral strategies to overcome feeding aversions this child might have?

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____

____

Any other restrictions or limitations we should be aware of? ________________________________

____

____

____

Please provide information below for the conditions the child currently has or has had in the past. For any that do not apply, leave blank.

GERD:

Circle one: ongoing GERD / GERD in the past

When did symptoms begin? (approx. date or child's age)

____

If in the past, when did symptoms end? (approx. date or child's age) ______________________________

Medications used: ______________________________

G-I diagnostics tests & results: *(upper/lower endoscopies, biopsies, etc.)* Date, test, result

____

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____

____

____

Other G-I problems or surgeries?

____

____

____

____

History of aspiration or aspiration pneumonia? # Incidents, approx. dates of occurrence

____

____

____

____

Modified barium swallow tests? *Please attach a copy of results. If unavailable, please summarize most recent dates and results here:*

____

____

____

____

____

Upper Respiratory/ENT problems:

___ frequent upper respiratory infections. Approx. # in last year ______________________________

___ Chronic sinusitis

___ Enlarged tonsils/adenoids. Surgically removed?

____

___ Ear infections. If yes, how many in last year?

____

Treatment for ear infections

____

Other:____

____

Hearing screened at birth? ____________

Results: Passed/Failed/Unknown (Circle one)

History of pulmonary/cardiac problems or surgeries?

____

____

____

Genetic screening? (Tests, results)

____

____

____

____

-Has child been seen by any of these specialists?

___ Genetics
___ Neurology
___ Gastroenterology
___Allergy
___ Orthopedics
___ Ophthalmology
___ Developmental Pediatrics
___ Psychology
___ Psychiatry
___ Otolaryngology
___ Endocrinology
___ Pulmonology
___ Other:

____

If copies of report summaries are available, please attach them.

Additional Comments:

____

____

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____

Physician Signature **Date**