FEED THE PEDS®

PEDIATRIC FEEDING SCREENING PACKET



#StartHere

\bigcirc	Print this off!
\bigcirc	Review Feeding Development Chart
	Complete Feeding Screening Form
\bigcirc	Fill Out Screening Results Form
\bigcirc	Make Any Necessary Referrals
	Share Results with
\bigcirc	Patient/Family/Team

All information, content and materials of this pediatric screener is intended for use by only qualified medical providers and is to be used as a screening tool to determine if further assessment is warranted. It is not intended to be used as a comprehensive feeding evaluation or comprehensive diagnostic tool.

Feeding Development

FEED THE PEDS® Name: _____ Age: ____ Date: _____

0		on		Já	aw	Lips	Tongue		0-3		
0-3	ling	Flexion		Phasi	ic Bite	Seals;		Breast or	3		
3-6	Pre-Crawling	Roll	T Hasic Dite			Functions as unit with tongue, cheeks,	Cups		3-6		
6-9		ă	Munch Chew		nch iew	palate	Protrusion	Bottle	6-0		
9		Sit		Diag Ch	gonal iew	Active lip movements	& Retraction	S	9		
9-12	Crawling	Stand	t e	70		Strips food from spoon	Lateralization	Spoon and cup	9-12		
12		Sta	e d B :	Soft Solid	>	Improved lip closure		cup	12		
12-18	ulator	Ibulatory Walk		ulator Walk	stain		y Chew	Jaw-lip-tongue o	dissociation	Straw	12-18
			Sus		tary			W			
18-24	An	_	/ p	Solid	R 0				18-24		
24		Run	o e	Hard Solid	ular	Chews with lips closed	Sweeps food from lips		24		
		Jump	ntro		Circ			Fork			
24-36		Ju	0 0				Tongue Tip Elevation during swallow		24-36		

Skills typically mastered by 36 months.

Feeding Screening Form

	Name:	Age:	Date
FEED THE PED	Concerns:		

BEHAVIORS	JAW	TONGUE	UTENSILS	
DroolingGag/CoughChokingOral Habit	StableExaggeratedThrustingClenching	FunctionalLow/ForwardThrustingBunched	BreastBottleSNSSpoon/ForkCup	
DIET	Tonic bite	CHEEKS		
○Thick liquids	Retraction	FunctionalImpaired	StrawFeedingTube	
OThin liquids	PALATE	Impaired		
○Pureed	Functional	LIPS	SUPPORT	
○Soft solid	○ Impaired	○ Competent	Independent	
○Hard solid	FACE	Olncompetent	Assisted	
SENSORY	Symmetrical	TONE	Supervision	
○Mixed	Asymmetrical		POSTURE	
Hyposensitive	MesocephalicDolchocephalic	○ High○ Low	O Posterior Pelvic Tilt	
HypersensitiveDefensive	Brachycephalic	OFluctuating	AnteriorPelvic TiltOther:	

	Name:	Age:	Date:
FEED THE PEDS®	Further Assessment Needed	(circle one): YES NO	

	FINDINGS	FURTHER ASSESMENT?	REFERRALS
F o r m Jaw			
esults Lips			
ning R Tongue			
S c r e e Cheeks			
Sensory			



Referral Form

Patient Name:	DOB:
Referring Provider:	Date:
Please evaluate for the following	g:

Additional Comments:



References

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