FEED THE PEDS®

PEDIATRIC FEEDING SCREENING PACKET

FEED THE PEDS®

#StartHere

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

Feeding Development

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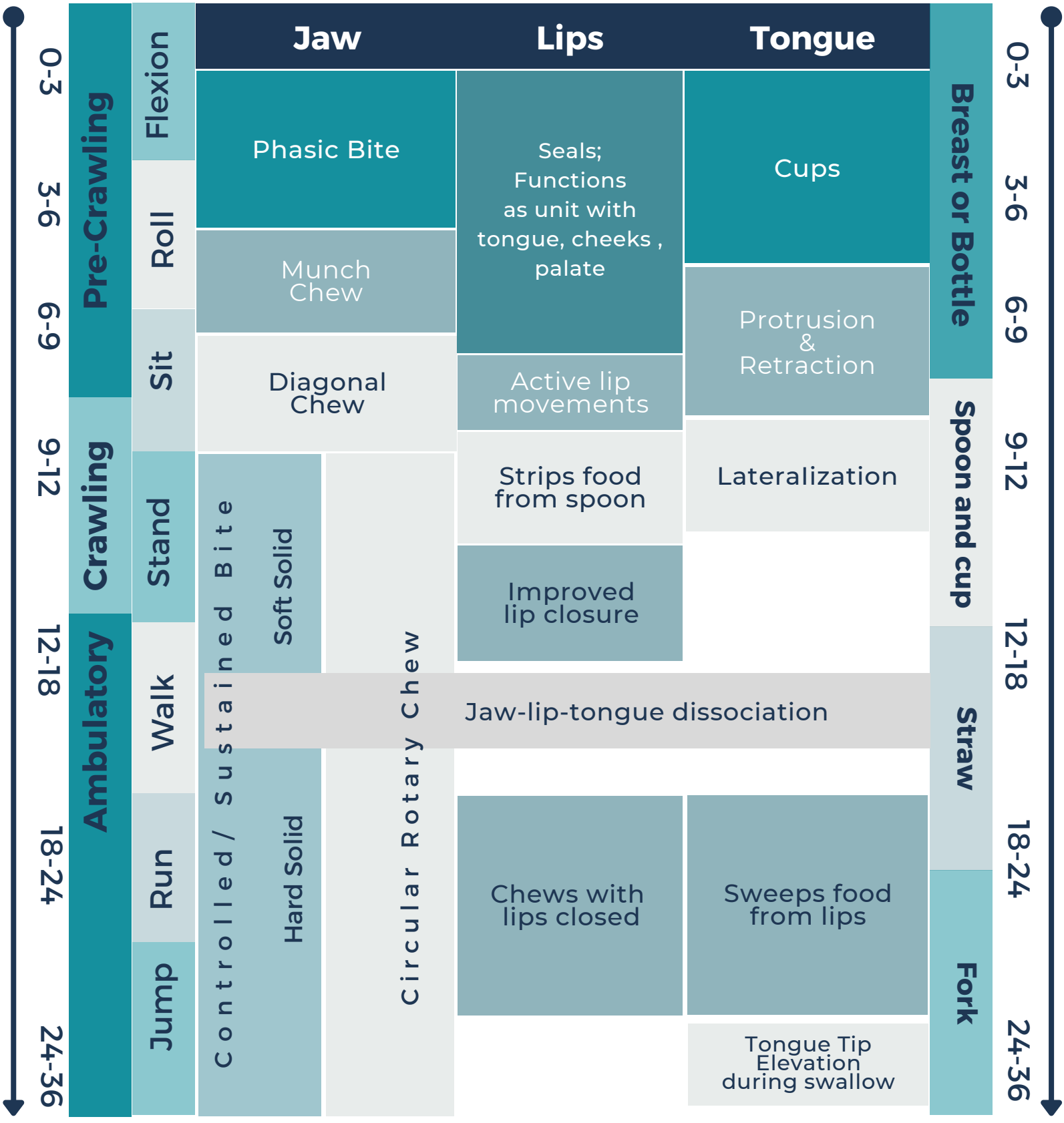
Name: _____ Age: _____ Date: _____

Concerns: _____



Skills typically mastered by 36 months.

Feeding Screening Form

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Name: _____ Age: _____ Date: _____

Concerns: _____

BEHAVIORS

- ◯ Drooling
- ◯ Gag/Cough
- ◯ Choking
- ◯ Oral Habit

DIET

- ◯ Thick liquids
- ◯ Thin liquids
- ◯ Pureed
- ◯ Soft solid
- ◯ Hard solid

SENSORY

- ◯ Mixed
- ◯ Hyposensitive
- ◯ Hypersensitive
- ◯ Defensive

JAW

- ◯ Stable
- ◯ Exaggerated
- ◯ Thrusting
- ◯ Clenching
- ◯ Tonic bite
- ◯ Retraction

PALATE

- ◯ Functional
- ◯ Impaired

FACE

- ◯ Symmetrical
- ◯ Asymmetrical
- ◯ Mesocephalic
- ◯ Dolchocephalic
- ◯ Brachycephalic

TONGUE

- ◯ Functional
- ◯ Low/Forward
- ◯ Thrusting
- ◯ Bunched

CHEEKS

- ◯ Functional
- ◯ Impaired

LIPS

- ◯ Competent
- ◯ Incompetent

TONE

- ◯ High
- ◯ Low
- ◯ Fluctuating

UTENSILS

- ◯ Breast
- ◯ Bottle
- ◯ SNS
- ◯ Spoon/Fork
- ◯ Cup
- ◯ Straw
- ◯ Feeding Tube

SUPPORT

- ◯ Independent
- ◯ Assisted
- ◯ Supervision

POSTURE

- ◯ Posterior Pelvic Tilt
- ◯ Anterior Pelvic Tilt
- ◯ Other:

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Name: _____ Age: _____ Date: _____

Further Assessment Needed (circle one): YES NO

Screening Results Form

	FINDINGS	FURTHER ASSESMENT?	REFERRALS
Jaw			
Lips			
Tongue			
Cheeks			
Sensory			

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Referral Form

Patient Name: _____ DOB: _____

Referring Provider: _____ Date: _____

Please evaluate for the following:

Additional Comments:

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References

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4. Developmental Motor Scales-Second Edition. Austin, TX: Pro-Ed.

5. Morris, S. E., & Klein, M. D. (2000). Pre-feeding skills: A comprehensive resource for feeding development. (2nd ed.). San Antonio, TX: Therapy Skill Builders.

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