Picky Eater/Feeding Therapy Referral Form

Child's Name: _____ Child's Age: _____

Referring Provider: _____

Provider Signature: _____

Parent/Guardian Signature_____

Parent/Guardian Phone #: _____ email address: _____

Observations or Parent Reported Behaviors:

- ☐ eats a limited variety of foods
- ☐ prefers all food at same temperature
- ☐ dislikes certain textures of foods
- ☐ rigid rules about food presentation (food can't touch, needs to be in a certain bowl, etc.)
- ☐ stuffs mouth with food when eating
- ☐ chews with mouth open
- ☐ eats too quickly
- ☐ needs water to swallow certain foods
- ☐ difficulty using a straw
- ☐ messy eating habits
- ☐ drools often
- ☐ poor weight gain
- ☐ choking, gagging, coughing during meals
- ☐ difficulty with transition to solid foods
- ☐ prefers grazing throughout day instead of eating meals
- ☐ avoids eating by playing or talking at the table
- ☐ needs constant reminders to keep eating (takes longer than 30 minutes to finish meals)
- ☐ wants the same food for more than 2 weeks in a row
- ☐ eating habits affect social gatherings (going to restaurants, birthday parties, sleepovers etc.)

Other relevant information - oral habits, aversions, behaviors, observations etc.

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please either fax or email form to 615.226.2839 or barb@sprockettherapy.com

Sprocket Therapy Solutions 615.226.2840 www.sprockettherapy.com/feeding-therapy