DEVELOPMENTAL FEEDING PILOT

Screener's Name:

Screen results:
Positive **Negative**

Screener Contact Information:

County where child lives:
Child's DOB:
Date of Screen:

Reason for Early Intervention Referral:

List any known medical diagnosis:

Child's Name:

Parent/Guardian Name/s:

Address:

Email address:

Phone Number:

Medicaid #/Insurance type:

Primary Care Provider:

Notes:

Suggested language to use:
I am going to ask you six questions about your child's eating habits and food experiences. These questions help spot early feeding or eating difficulties in babies or toddlers. Do you have any concerns about your child's eating or nutrition? If so, we have resources to support you and your child.

Ask the 6 questions below and circle the responses.

If the screen is positive: (2 or more red answers): refer to an OT or SLP feeding specialist & a pediatric dietitian for further assessment. They will consult with your EI team and the child's medical provider regarding results of their assessment. Please fill out the the gray area and the demographic information on the left prior to referring to the OT or SLP and the dietitian.

If the screen is negative: Fill out the information in the gray area and submit the form to the designated person.

If you or the family has questions about this screening tool: please contact your supervisor or the CSHN Nutrition Network via email at: ahs.vdhcshnnutrition@vermont.gov

Infant and Child Feeding Questionnaire

Does your baby/child let you know when he or she is hungry?	Yes	No	
Do you think your baby/child eats enough?	Yes	No	
How many minutes does it usually take to feed your baby/child?	<5	5- 30	>30
Do you have to do anything special to help your baby/child eat?	Yes	No	
Does your baby/child let you know when he or she is full?	Yes	No	
Based on the questions above, do you have concerns about your baby/child's feeding?	Yes	No	

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