Children with Special Health Needs (CSHN) Nutrition Services Referral Form

August 2026

Use this form to refer a child for nutrition services through the CSHN Community Nutrition Network. A Registered Dietitian will contact the family to set up an evaluation and any follow-up visits.

Send the completed form via email to: AHS.VDHCSHNNutrition@vermont.gov or Fax to 802-862-7635. Also include: growth charts, current problem list, and current medication.

If you need help accessing or understanding this information, contact AHS.VDHCSHN@vermont.gov or 802-863-7338.

Referral source

Today's date * *(required)*

Your name * *(required)*

Title and organization

Phone * *(required)*

Email * *(required)*

Child and family information

Child's name * *(required)*

Child's date of birth * *(required)* MM / DD / YYYY

Parent or guardian * *(required)*

Address (street, city, ZIP) * *(required)*

Parent phone * *(required)*

Parent email

Medical and health information

Diagnosis or condition * *(required)*

Reason for nutrition referral * *(required)*

Primary care provider * *(required)*

Recent height / weight / date

Insurance

☐Medicaid ☐ Private insurance ☐Uninsured

Medicaid number / private carrier

Optional: Infant and Child Feeding Questionnaire (ICFQ) screen

If the ICFQ screener was used, please share the result so we can prioritize the referral.

☐ Positive (2+red answers) ☐ Negative☐ Not completed

Family Consent

By signing, I confirm I have discussed this referral with the family and have their consent to share this information with the CSHN Nutrition Program.

Signature * *(required)*

Date signed * *(required)*

When to refer – quick reference

Consider a CSHN nutrition referral when a child shows any of the following. This is not exhaustive — if you are unsure, call or email us.

Growth and nutrition	Feeding skills and behavior
• Difficulty gaining weight or growing • Overweight for height • Limited dietary variety • Reliance on supplements or formula • Tube feeding (NG, GT, TPN) • Suspected food allergies • Constipation or digestive issues • Diagnosis with specific nutrient needs	• Mealtimes longer than 30 min or shorter than 5 min • Coughing, choking, or gagging while eating • Cannot safely eat by mouth • Refuses textures or food groups • Unable to transition to solids • Stress, fear, or conflict at mealtimes • Need for thickened liquids or modified textures • Positive ICFQ feeding screen

Before you submit

☐I have discussed this referral with the family and have their consent.

☐I have attached growth charts and growth data (primary care providers).

☐I have attached the current problem list and current medication list.

☐All required fields above are complete.

Questions — call us	Email us anytime	Fax
802-232-2517	**AHS.VDHCSHNNutrition@vermont.gov**	**802-863-7635**

Accessibility: *If you need this form in a different format, contact AHS.VDHCSHN@vermont.gov or call 802-863-7338.*

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DEPARTMENT OF HEALTH