



THE
INSTITUTE
FOR INFANT FEEDING
AND EARLY DEVELOPMENT

INFANT REFERRAL

SPECIALIZED INTERDISCIPLINARY CARE
FOR INFANTS BIRTH THROUGH 12 MONTHS

INFANT INFORMATION

Infant's name _____ Date of birth _____

Parent / guardian _____ Phone _____

REQUESTED SERVICES

☐ **NICU follow-up evaluation**

☐ Feeding and swallowing

☐ Development

☐ Infant nutrition

☐ Breastfeeding / lactation

☐ Other: _____

AREAS OF CONCERN

☐ Breastfeeding / lactation

☐ Bottle feeding

☐ Coughing, choking or congestion during feeds

☐ Signs and symptoms of aspiration

☐ History of dysphagia

☐ Poor weight gain or growth

☐ Reflux or feeding discomfort

☐ Other: _____

☐ Oral motor inefficiency

☐ Feeding refusal or aversion

☐ Prematurity

☐ Torticollis, head shape or positioning

☐ Tube feeding history

☐ Transition to solids

☐ Developmental delay

CLINICAL INFORMATION

Diagnosis / ICD-10 _____

Relevant history, precautions or clinical notes

☐ **Please evaluate and treat as clinically indicated**

☐ Evaluation & recommendations only

REFERRING PRACTITIONER

Name and credentials _____

Practice _____

Phone _____ Email _____

NPI _____ Signature _____ Date _____

PROVIDER OFFICES Scan the QR Code to Submit this form online!

FAMILIES Call 972-836-7080 to schedule.

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