Joya
CHILD & FAMILY DEVELOPMENT

Neurodevelopmental Center of Excellence

Joya Nutrition Referral

Child's Name:	Child's DOB:
Referred by:	Date:

How does your child receive nutrition? *Please check all that apply.*

☐ **Breastfeed**

How frequent?
How long per feed?
How many times per 24 hours?

☐ **Bottle Feed**

How frequent?
How long per feed?
How many times per 24 hours?
Volume per feed?
What formula/milk type?
Formula/Milk recipe:

☐ **Feeding Tube**

Tube Type:
How frequent?
How long per feed?
How many times per 24 hours?
Volume per feed?
What formula/milk type?
Formula/Milk recipe:

What other liquids does your child drink?
Daily volume per 24hrs:
If taking solids, what times does your child eat?

Does your child have any food allergies or intolerances?	☐ Yes ☐ No
If yes, please explain food allergies/intolerances:	

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Foods your child likes:
Foods your child dislikes:

Does your child have any of the following with feeding. If yes, please describe below.

☐ Difficulty latching to breast/bottle	☐ Tiring	☐ Gagging	☐ Picky
☐ Coughing/Sputtering Texture Sensitivities	☐ Overstuffs mouth	☐ Arching	
☐ Retching	☐ Pocketing food in cheeks	☐ Other	
Please describe:			
If picky eater, please explain. (few foods, texture, small amounts)			

Does your child have any of the following GI concerns? If yes, please describe below.

☐ Spitting Up	☐ Reflux	☐ Constipation
☐ Abnormal Stool	☐ Diarrhea	☐ N/A
Please describe:		
How often does your child have a bowel movement?		

Difficulty with bowel movement?	☐ Yes ☐ No
Does your child see a Registered Dietitian?	☐ Yes ☐ No
If yes, who?	
Is your child enrolled in WIC?	☐ Yes ☐ No
If yes, which location?	