

Birth to 3 Nutrition Screening Tool

Child's Name: _____ Birthdate: Month _____ Day _____ Year _____

Parent/Caregiver: _____ Phone #: _____

Address: _____

Person completing screen: _____ Title: _____

Birth to 3 Agency: _____ Phone Number: _____

SECTION 1 - Medical Conditions

Your child may have one or more of the following conditions. Please place a check by each of your child's conditions.

- | | | |
|---|--|---|
| <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Organ transplant |
| <input type="checkbox"/> Bronchopulmonary dysplasia (BPD) | <input type="checkbox"/> Down syndrome | <input type="checkbox"/> Prader-Willi Syndrome |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Cerebral palsy (CP) | <input type="checkbox"/> FAS/ drug exposure | <input type="checkbox"/> Spina bifida |
| <input type="checkbox"/> Chromosomal/congenital disorder | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Technology dependent (trach, vent, etc.) |
| <input type="checkbox"/> Cleft lip and/or palate (unrepaired) | <input type="checkbox"/> Lead exposure | <input type="checkbox"/> Very low birthweight (1500g or less) |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Metabolic disorder
(PKU, galactosemia, diabetes, etc.) | <input type="checkbox"/> > 6 weeks premature |
| <input type="checkbox"/> Other: _____ | | |

SECTION 2 - Current Growth, Health and Feeding Concerns

You or your child's doctor may have concerns about your child's growth. Please place a check by each of the concerns that either you or this doctor has for your child.

Small for age Lack of weight gain Excess weight gain Weight loss Other: _____

You may currently be concerned about any of the following nutrition-related symptoms for your child. Please place a check next to your current concerns that have lasted longer than 1 month.

Constipation Poor appetite Diarrhea Vomits/reflux Use of a special formula or diet
 Tube feeding Other: _____

You or others who care for your child may have concerns about your child's feeding/eating. Please place a check by each of the concerns that you or others have for your child.

- | | |
|---|--|
| <input type="checkbox"/> Usually takes longer than 30 minutes to feed | <input type="checkbox"/> Formula-fed infant drinks less than 16 ounces in 24 hours (3-12 months) |
| <input type="checkbox"/> Difficult to feed | <input type="checkbox"/> Breast-fed infant nurses less than 6 times in 24 hours (birth-9 months) |
| <input type="checkbox"/> Gags or chokes often | <input type="checkbox"/> Refuses solid foods/certain textures (over 12 months) |
| <input type="checkbox"/> Eats non-food items | <input type="checkbox"/> Does not self-feed (over 15 months) |
| <input type="checkbox"/> Has difficulty sucking, swallowing,
or chewing | <input type="checkbox"/> Needs bottle for most liquids (over 18 months) |
| <input type="checkbox"/> Feedings are stressful or upsetting to my child or me. | <input type="checkbox"/> Lack of food or infant formula in the household to meet child's needs |
| <input type="checkbox"/> Current unresolved food allergies/intolerances: _____ | |
| <input type="checkbox"/> Other feeding/eating concerns I have for my child: _____ | |
| _____ | |

Nutrition Assessment Referral/Service Coordination

If this child has a medical diagnosis from SECTION 1 and one or more nutritional concerns checked in SECTION 2, OR if this child has two or more nutritional concerns in SECTION 2, it is recommended this child receive a nutrition assessment by a Registered Dietitian (RD).

Please check one of the following statements as indicated by the screening results from page one. Continue as instructed by the statement you check.

- Meets criteria for nutrition assessment referral, continue below.
- Does not meet criteria for nutrition assessment referral. Re-screen in 6 months or earlier as needed.
- Parent/caregiver not interested in nutrition assessment referral at this time.

1. If this child is **currently seen by a RD**, enter the RD's name on line 1.
2. If this child is **not currently seen by a RD**, and a referral can be made through the primary care provider (PCP), enter the PCP's name on line 2.
3. If this child does not currently have a primary care provider, or the primary care provider is unable to arrange for a nutrition assessment by a RD, or a **direct referral to a Birth to 3 RD** is desired, enter the Birth to 3 RD's name on line 3.

1.	<i>Current RD and Clinic name</i>
or	
2.	<i>PCP and Clinic name</i>
or	
3.	<i>Birth to 3 RD name</i>
<i>Address</i>	
<i>Telephone</i>	<i>Email</i>

Parent/Caregiver Consent for Referral:

I, as my child's parent/caregiver give consent for the referral above. I understand this referral is for the purpose of arranging for my child to receive a nutrition assessment. I authorize communication between the Birth to 3 Program, Registered Dietitian and primary health care provider regarding my child's nutrition care. I understand that my consent is valid for one year from the date that I sign. I further understand that medical and Birth to 3 records may be shared among the Registered Dietitian, Primary Care Provider and Birth to 3 Program to coordinate my child's nutrition care.

X _____ Date: _____

If the child meets the criteria for a nutrition assessment referral and a referral is not made, please explain why: _____