|  |  |
| --- | --- |
| **Date of Referral:** | **Consent given for Dietetics Referral by:** |
| \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ | Patient  No capacity: referred in Best Interest |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | |  | | | **NHS Number** | |  |
| **DOB** | |  | | | **Registered GP** | |  |
| **Address**  **Telephone** | |  | | | | | |
| **MUST Score:** | **Weight & date taken:** | | **Height:** | **BMI:** | | **Previous Weight & date taken:** | |
|  |  | |  |  | |  | |

|  |  |
| --- | --- |
| Name of Referrer |  |
| Role (e.g. GP) |  |
| Address/Location |  |
| Telephone Number |  |

|  |  |
| --- | --- |
| **Reason for Referral (please tick)** | **Essential Referral Information (please complete)** |
| Malnutrition/Nutrition Support | Height, BMI and weight history provided above  Food Fortification implemented  for minimum 1 month (community) or 1 week (inpatient)  First Line oral nutritional supplements prescribed  for minimum 1 month (community) or 1 week (inpatient) |
| Tube Feeding (Community Hospital) | New  Existing Tube Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Pressure Ulcer | Height, BMI and weight history provided above  Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_ Area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Irritable Bowel Syndrome (IBS)  (*group session)* | Recent TTG, FBC and CRP tests are all normal  No outstanding GI investigations |
| Coeliac Disease | Diagnosis confirmed by secondary care |
| Inflammatory Bowel Disease (IBD) | Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Liver Disease |  |
| Pancreatitis/Pancreatic Insufficiency |  |
| Oncology *(please complete MUST)* | Height, BMI and weight history provided above |
| Renal Impairment | CKD Stage: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Please provide supporting information on next page*** | |

**Diabetes referrals: please direct any diabetes referrals to your local team.**

**Medical History***including any relevant diagnoses/investigations, blood test results, Speech and Language recommendations*

**Medications**

**Supporting Information**   
*e.g. 6 month weight history, social information/carers, discharge location*

**Appointment Type**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are they able to attend an outpatient appointment? | | | Yes | | No |
| Do they require a carer, family or friend present?  *If Yes, please state name and contact details if known:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | Yes | | No |
| Do they have difficulty communicating?  *If yes, please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | Yes | | No |
| If required, is there someone who can assist or communicate on their behalf? *If Yes, please state name and contact details if known:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | Yes | | No |
| Is there a known history of violence/harassment, alcohol or drugs abuse from the person/family? Are there any alerts surrounding safety of lone working?  *If yes, please state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | Yes | | No |
| Which type of scales are required? | Stand-on | Wheelchair | | Hoist | |
| Any other relevant information or alerts: | | | | | |