|  |  |
| --- | --- |
| **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 prescribedfor minimum 1 month (community) or 1 week (inpatient) |
| [ ]  Tube Feeding (Community Hospital) | [ ]  New [ ]  Existing Tube Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Pressure Ulcer | [ ]  Height, BMI and weight history provided aboveGrade: \_\_\_\_\_\_\_\_\_\_\_\_\_ 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: |