Dorset HealthCare University NHS Foundation Trust

COMMUNITY & SPECIALIST DIETETIC SERVICE

(Providing a Service in the areas of Bournemouth, Poole, Purbeck, Christchurch & East Dorset)

Dietetic Referral Criteria – Adults

All referrals for adults that meet the access criteria should be sent to - **Community & Specialist Dietetic Service, Sentinel House, 4-6 Nuffield Road, Poole BH17 0RB**

Or emailed to **dhc.dietetic.referrals@nhs.net**

Condition	First line	Diet sheet/resources/ website	When to refer to Community Dietitian
Allergy **Food Allergy or Intolerance**	Suspected Food Allergy should have blood tests to confirm diagnosis	www.allergyuk.org	Community Dietitian referral for trial of exclusion diet to assist diagnosis of allergy/intolerance and check nutritional adequacy of diet
Cardiovascular Disease (CVD)	To be managed in Primary Care	www.heartuk.org.uk www.bhf.org.uk	Due to the high incidence of CVD, it is not feasible to accept these referrals
Coeliac Disease Newly diagnosed Established Coeliac Disease (CD)	Refer to secondary care Gastroenterology clinics at PHT or RBCH	Encourage patient to join www.coeliac.org.uk	Community Dietitian referral if CD established and require review
Diabetes (DM) **Type 1 DM Newly diagnosed** **Type 2 DM Newly diagnosed**	Diabetes Consultant at acute trust for referral to the Diabetes Dietitian Diabetes Education Programme – GP referral	www.diabetes.org.uk	

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Diabetes over one year post diagnosis with poor glycaemic control and on at least one medication for diabetes	Poor control includes raised HbA1c, erratic blood glucose levels, frequent hypos, excessive weight gain (for people on insulin or sulphonylureas), or unintended weight loss	www.diabetes.org.uk	Refer to Intermediate Diabetes Team, Tel 01202 448061 **Refocus** (type 2 diabetes group refresher education) Email referral form to: dhc.diabetes.refocus@nhs.net or tel: 01202 448061
Dysphagia	Referral to Speech & Language Therapist (SLT) to confirm dysphagia diagnosis and IDDSI Food & Drink descriptor*	High calorie, texture modification information sheets available from SLT	Community Dietitian referral following SLT assessment if MUST 2 and nutritional concerns **or** where weight loss is likely due to a chronic neurological condition e.g. MND
Eating Disorders (Anorexia Nervosa/Bulimia Nervosa) **Disordered Eating**	Referral into Eating Disorders team at St Ann's – Kimmeridge Court, 69 Haven Road, Canford Cliffs, Poole BH13 7LN 01202 492147	www.eating-disorders.org.uk www.b-eat.co.uk www.Steps2wellbeing.co.uk	For disordered eating only - Community Dietitian referral but psychological support for the patient is essential e.g. Steps2Wellbeing
Enteral (tube) feeds	Enteral feeds include nasogastric, gastrostomy or jejunostomy feed	www.bapen.org.uk	Refer all home enteral feed patients to Home Enteral Nutrition Dietitian Tel 01202 711531 or Email HEN.East@dhuft.nhs.uk
Gastrointestinal conditions/IBD e.g. Crohns Disease, Ulcerative Colitis	Refer to secondary care Gastroenterology clinics at PHT or RBCH. Patient will be referred on to Specialist Dietitian as part of secondary care team.	www.corecharity.org.uk www.crohnsandcolitis.org.uk www.stmarkshospital.org.uk	

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Diverticular disease	To be managed in primary care Any sudden change in bowel habit must be investigated through GP first.	https://gutscharity.org.uk/wp-content/uploads/2018/08/Guts-UK-Diverticular-Disease-Leaflet.pdf	If symptoms are ongoing despite first line advice then Community Dietitian referral
Chronic constipation or Diarrhoea	Manage within primary care or consider referring to Dorset Bladder & Bowel Continence Service , 11 Shelley Road, Bournemouth, BH1 4JQ Tel: 01202 443111	https://gutscharity.org.uk/wp-content/uploads/2018/08/Guts-UK-Constipation-Leaflet.pdf	It is not feasible to accept these referrals, unless they have a diagnosis of IBS alongside these
Other gastro e.g. /Reflux/Hiatus Hernia	Manage within primary care	www.nhs.uk/conditions/ and search condition	It is not feasible to accept these referrals, unless they have a diagnosis of IBS alongside these
Impaired glucose tolerance (IGT)	Manage within primary care Consider weight management (see later) Diabetes Prevention Programme run by NHS – Living Well Taking Control	www.patient.co.uk www.LiveWellDorset.co.uk 'Know your risk' assessment for risk of Type 2 Diabetes at www.diabetes.org.uk www.lwtcsupport.co.uk Tel 0330 223 3706	Due to the high incidence of IGT, it is not feasible to accept these referrals
Irritable Bowel Syndrome (IBS)	Blood tests to exclude Coeliac Disease, IBD and other Red Flags before appointment booked as per NICE Guideline CG61	Give first line dietary advice sheet available from www.bda.uk.com/ foodfacts www.theibsnetwork.org	Community Dietitian referral if no improvement after four weeks following first line advice

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	Faecal Calprotectin test as per Dorset pathway		Do not ask them to start the low FODMAP diet before they have seen a Dietitian
Malnutrition /Nutrition support	Screen patient for malnutrition using **MUST** tool (Malnutrition Universal Screening Tool) If MUST 0 or 1 - Follow Action Plan regarding Food Fortification and use of Over The Counter (OTC) Supplements	MUST tool on SystmOne for Dorset HealthCare S1 users www.bapen.org.uk www.dorsetformulary.nhs.uk Search Nutrition then scroll to Pathway for Prescribing Oral Nutritional Supplements (ONS)	Community Dietitian referral if MUST 2 or more & no improvement after 4 weeks following Food Fortification **or** where weight loss is unlikely to be short term issue due to a chronic medical condition e.g. MND **or** if patient has lost >15% body weight in less than three months
Renal impairment	Determine Stage of chronic kidney disease and provide blood results (especially potassium). Stage 4/5 usually under Renal Team and Specialist Dietitian at PHT/RBCH/DCH	www.kidneypatientguide.org.uk www.kidneyresearchuk.org/health-information/stages-of-kidney-disease	Stage 1, 2 and 3 Community Dietitian referral if MUST 2 or more & no improvement after 4 weeks following Food Fortification Stage 4/5 and not under Renal Team, refer to Community Dietitian if MUST of 2 or more
Weight Management	BMI >25 -30 Manage in Primary Care BMI >30 Refer to Healthy Choices Scheme through Live Well Dorset Tel: 01305 233106	www.nhs.uk/change4life For psychological support www.Steps2wellbeing.co.uk	Community Dietitian referral for Weight Management if BMI >40 **or** BMI >35 with Learning Disability **or** BMI >35 plus 1 or more

	www.livewelldorset.co.uk/	For self-management support contact My Health My Way Tel 0303 303 0153 Tier 3 services www.theweighahead.com	co-morbidities (see end)** **or** BMI > 30 pre/early pregnancy **or** BMI > 30 taking antipsychotic medications known to induce weight gain

*__IDDSI__ – International Dyspahgia Diet Standardisation Initiative See https://iddsi.org/

** **Significant co-morbidities associated with adult weight management**

Type 2 diabetes
Significant family history of type 2 diabetes
Metabolic syndrome
Uncontrolled high blood pressure
Cardiovascular disease, including stroke
Sleep apnoea
Polycystic Ovarian Syndrome (PCOS)
Infertility
Stress incontinence
Psychological: depression, low self esteem
Awaiting surgery for musculoskeletal disease
Respiratory disease
Non-Alcoholic Fatty Liver Disease (NAFLD)

Who can refer to the Community Dietitian?

Registered Dietitians (all Dietitians in the Community & Specialist Dietetic Service are registered with the Health and Care Professions Council) can accept referrals from all Registered Health Professionals and staff in Care & Nursing Homes. As part of a Registered Dietitians duty of care they will notify the GP/Consultant of any referrals received for their patients.

How should I refer and what information should I provide?

You may refer your patient by completing our updated Referral Form (October 2018).

E mail to **dhc.dietetic.referrals@nhs.net** or post to Community & Specialist Dietetic Service, Parkstone Health Centre, Mansfield Rd, Parkstone, BH14 0DJ

Alternatively, you can refer by letter, but you must include all the information indicated on the referral form. Incomplete referrals will be sent back.

Referrals must meet one of our referral criteria indicated above and include the latest relevant blood results and medication (please attach an electronic summary if available). Failure to provide this information may result in delayed access to the Dietitian.

If you wish to refer a patient and are unsure if they meet our criteria, please call us to discuss further. Occasionally a health condition not listed may benefit from Dietetic input. Please call if you wish to discuss a particular patient.

Community & Specialist Dietetic Service 01202 733323.

Domiciliary Visits

Please consider first whether the patient can get to a clinic (if Hospital transport is necessary this should be arranged by the GP Practice). Or consider whether a telephone appointment may be suitable. Only if neither of these is feasible, will a domiciliary visit be considered.

Patients in Care Homes

Patients may be referred to the Community Dietitian by any member of staff; they will then be assessed and reviewed by telephone with the Care Home staff. Visits to Care Homes are not usually made; however, nutrition training for staff is available. Please contact the Community Dietitian for further information.

Making a Dietetic appointment

Please note that your patient will not be automatically sent an appointment. They will be sent a letter asking them to call the Community & Specialist Dietetic Service to book an appointment. This allows patients to choose which clinic they would like to have an appointment at. They will also be sent our Service leaflet detailing what to expect at their appointment. You will be informed if a patient fails to book an appointment (non-responder).

The Dietetic Appointment

A first appointment will usually be 30-45 minutes long and a follow up appointment is usually 15-30 minutes long. We will write to you after the first appointment to advise you of the planned intervention and dietary changes advised.

Normally up to two follow up appointments will be offered after which we will usually discharge the patient back to your care. Weight management patients may have up to six appointments. Where appropriate, on discharge, we will provide the patient with written dietary information, advice on self-care, a local support group and/or suggestions on how you may further support them in Primary Care.

Some patients may be discharged with an option to contact us for further help within six months if necessary. If more than six months elapses since the patient was last seen we will require a re-referral.

Dietetic records and correspondence are recorded using SystmOne and are therefore accessible to some other Health Professionals. We will send you an electronic copy of our letter, or a message to read our entry/letter on SystmOne. If this is not possible a hard copy of any letters will be sent unless you advise otherwise.

Patients who Do Not Attend (DNA) or Cancel their Appointment

Patients who Do Not Attend (DNA) will be sent a DNA letter inviting them to rebook. If they do not rebook within 4 weeks they will be discharged and the referrer informed.

If there are safeguarding concerns for Children or Adults there will be discussion with the referrer about offering another appointment.

Patients who cancel appointments will have 4 weeks to rebook, otherwise they will be discharged.

Rebooking appointments beyond these circumstances is done at the discretion of the Dietitian.

It is important that patient contact details are correct, including landline and mobile telephone numbers so contact can be made.

Do these Referral Criteria apply to all patients?

Adults with Learning Disabilities - All referral criteria relate to patients with a Learning Disability who may be seen within the general clinics.

Mental Health - all patients with a Mental Health condition that have dietary problems that fall into our referral criteria should be referred to the Community & Specialist Dietetic Service, except for clients with a diagnosed Eating Disorder who should be referred directly to the Eating Disorder unit at St Ann's Hospital.

Children – please refer all children that meet the referral criteria to the Community & Specialist Dietetic Service. If appropriate we may direct some patients to the Children's Dietitian at Poole Hospital. See 'Dietetic Referral Criteria - Children'.

Safeguarding – Please ensure any potential safeguarding concerns are shared.

Further information about the Community Dietetic Service

Dorset Healthcare Trust staff, please go to DORIS/Patient Care/Dietetics

www.doris.dhc.nhs.uk/

Staff outside of the Trust, please go to

www.dorsethealthcare.nhs.uk/ and search Dietetics.