**REFERRAL FORM FOR COMMUNITY NUTRITION AND DIETETICS SERVICES**

**THESE SECTIONS ARE MANDATORY AND REFERRAL WILL BE RETURNED IF NOT COMPLETE**

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| Surname: | Forename(s): |
| D.O.B: M/ F: Has the patient/proxy agreed to referral: [ ]  Y / [ ]  N  | NHS Number: Patient aware of Referral: [ ]  Y / [ ]  NGP aware of Referral: [ ]  Y / [ ]  N |
| Address:Telephone/Contact No:  | Next of Kin/ Carer: (state name, relationship and contact details)Does the patient/proxy agree to information being shared with a third party: [ ]  Y / [ ]  NIs the patient suitable to come to clinic: [ ]  Y / [ ]  N |
| Interpreter needed? [ ]  Yes / [ ]  No -Language preferred :Main spoken language English | Ethnicity:  |
| GP: Practice Address: | If the patient has swallowing difficulties, have they been seen by SALT already?: [ ]  Yes / [ ]  NoIF NO, refer to SALT first |
| Reason for dietetic referral:[ ]  Diabetes - Group or Individual[ ]  Nutrition Support – complete sheet overleaf [ ]  Other: Specify details belowPressure sore: [ ]  Yes / [ ]  NoGrade:  | Diagnosis:Past medical History:Current medication: |
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|  |
| **Referrer Details:**  |  |
| Name (please print):  | Job Title: Team:  |
| Signed:  | Date of Referral: Contact number:  |
| Please complete the attached sheet for all referrals.**Ensure all fields are completed or the referral will be returned to you.****Patient name and Surname:**  **NHS number:**  |
| Is patient known to Dietetics: [ ]  Yes / [ ]  No |
| Other Services involved(e.g. SALT, Older Persons Mental Health, Community Learning Disability Team, Specialist Nurses, Social Services):Name and Contact number:  |
| Diversity needs: (Mental Health /Visual or hearing impairment / Communication difficulties) ,  |
| **COMPLETE FOR ALL REFERRALS:** **THIS MUST BE COMPLETED** Weight(kg): Height(m): BMI(kg/m2): MUST Score: MUAC (cm): Weight change over last 3-6 months: If you have no recent weight information available please complete the following numbered questions1. Are rings usually worn (such as wedding ring) a lot looser than they were 6 months ago: [ ]  Yes / [ ]  No2. Have they dropped dress/trouser size in the last 6 months: [ ]  Yes / [ ]  NoIf yes provide details of original size and current size3. Are the patient’s bones visually prominent in the following areas: Spine [ ]  Yes / [ ]  No Collar bones [ ]  Yes / [ ]  No Sternum [ ]  Yes / [ ]  No Cheek bones [ ]  Yes / [ ]  No**COMPLETE THE FOLLOWING FOR NUTRITION SUPPORT REFERRALS**Have you followed the South Tees Pathway For The Management of Undernutrition: [ ]  Yes / [ ]  NoHave you given the ‘Dietary Advice To Help Nutritional Intake’: [ ]  Yes/ [ ]  No Supplements already trialled: [ ] Yes / [ ]  No Date started: If yes, state which ones and by whom initiated:  |
| Supplements Currently Prescribed and Taken: |
| **Dietary requirements: (please tick all that apply)**[ ]  Normal Diet [ ]  Level 6 / Soft and bite size ( Texture E)[ ]  Level 5 / Minced and moist ( Texture D)[ ]  Level 4/ Pureed (Texture C diet)[ ]  Assisted Feeding [ ]  Diabetic [ ]  Vegan [ ]  Coeliac [ ]  Other (i.e. allergies)[ ]  Dietary likes and dislikes: **Fluid consistency**: [ ]  Normal [ ]  Level 1 : Slightly thick [ ]  Level 2: Mildly thick (stage 1/ Syrup) [ ]  Level 3: Moderately thick (Custard)  |
| Activity level of patient: | Additional information (specific reason for home visit rather phone call/clinic, include any lone working concerns/issues): |
| **Please send completed referral to Postal address: Nutrition and Dietetics, Langbaurgh House, Bow Street, Guisborough, TS14 7AA or Email:** ste-tr.guisboroughdietitians@nhs.net  |