South Tees Hospitals NHS
NHS Foundation Trust

Directorate: Clinical &Diagnostic Services Centre

Referral for Community Nutrition & Dietetic Services

*Please ensure that **all** fields are completed including NHS number, failure to do so will delay the processing of the referral.* ***If there is insufficient information the referral will be returned to you.***

Surname:	Forename(s):
D.O.B: ☐☐ ☐☐ ☐☐☐☐ M / F	NHS no: ☐☐☐ ☐☐☐ ☐☐☐☐
Address: Postcode: Telephone/Contact No:	Alternative Address *(if not staying at own premises e.g. in respite / on community ward)* Address: Postcode: Telephone/Contact No:
Is an interpreter needed?: Yes / No Language preferred:	Ethnicity:
GP: Practice Address:	Next of Kin/carer: (*state name, relationship and contact details)*
Consultant name: *(if applicable)*	Date of Admission & Ward No/Name: *(if applicable)*
Reason for dietetic referral:	Diagnosis:

If palliative patient (please tick):
Is the patient on the Gold Standards Framework: Yes ☐ No☐ Unknown ☐
Is the patient on the Last Days of Life Care Pathway: Yes ☐ No☐ Unknown ☐
Is the patient aware of their prognosis: Yes ☐ No ☐
Are they having any palliative treatment: Yes ☐ No ☐
If yes please give details including where they are having treatment:

Main symptoms affecting oral intake (please tick):
Vomiting ☐ pain ☐ diarrhoea ☐ constipation ☐ swallowing difficulties ☐ other please state……

Referrer Details:

Name: (Please print):	Job Title:
Address & Contact No:	GMC/Registration/PIN No: *(if applicable)*
Signed:	Date of referral:

Continued overleaf

Medical history (including investigations/treatments):

Current medication:

Recent relevant blood tests (if available):

Weight (kg): Height (m): BMI (kg/m^2): MUST score: MUAC (cm):

Weight change over last 3-6 months:

Have you followed the South Tees Pathway to Manage Undernutrition prior to this referral?:

Food fortification tried: Yes / No Date started:
If yes give brief details:

High calorie drinks and snacks trialled: Yes / No Date started:
If yes state which ones:

Food & drink chart been started: Yes / No Date started:
If yes please attach recent food charts (3 days)

Supplements already trialled: Yes / No Date started:
If yes state which ones:

If the patient has swallowing difficulties have they been seen by SALT already?: Yes / No
If no refer to SALT first

Other involved services (e.g. SALT, Social Services, Specialist Nurses):
Name and contact number

Diversity Needs: (*i.e. mental health issues / visual problems / hearing problems / allergies*)

If the patient lives in their own home, is a home visit is necessary? Please state the reason(s) why:

Identified Risks: (*i.e. dogs, unusual access, lone worker issues, safety issues)*

☐ Please tick this box if you wish to discuss the referral further including giving further information on any safety issues which may protect the lone workers in this service

Additional information:

Please send completed referral to:
Email: ste-tr.guisboroughdietitians@nhs.net
Or post to: Patient Connect (Nutrition & Dietetics Service), 2nd Floor Murray Building, James Cook University Hospital, Marton Road, Middlesbrough, TS4 3BW