**Dietetic Referral Form**

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| Please complete this form fully and return to:  **Nutrition & Dietetic Services,**  **St Martin’s Hospital, Bath, BA2 5RP**  or email it to [ruh-tr.referralsSMHdietitians@nhs.net](mailto:ruh-tr.referralsSMHdietitians@nhs.net).  Please note that this email address is for referrals only.  If the referral is urgent please telephone the Dietetic  Department on 01225 833916.  ***Please note that incomplete forms may be returned***. | For official use only   |  |  |  |  | | --- | --- | --- | --- | | **Date Rec** | |  | | | Triage | Send appt |  | | | Tel appt |  | | | Home Visit |  | | | Group | CHO | Xpert | | MF | IBS | | Tick if urgent |  | | | Appt | Date of appt |  | | | Time & place |  | | | Tick if prev r/card | |  | | |

**Patient Contact Details**

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| Title:<Patient Name>  Name:<Patient Name>  Address: <Patient Address>  Postcode: <Patient Address>  Tel no:<Patient Contact Details> | Email Address:<Patient Contact Details>  Mobile no:<Patient Contact Details>  Does patient consent to message being left on answer phone?  Yes  No  Does patient consent to email correspondence?  Yes  No  Does patient consent to text message correspondence?  Yes  No |

**Patient Details**

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| DoB:<Date of Birth>  NHS no: <NHS number> | Gender:<Gender>  Ethnic group:<Ethnicity> |

**GP and Next of Kin Details**

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| GP Name: <GP Name>  GP Practice address: <GP Details>  Postcode:  Tel no.:<Patient Contact Details> | Next of Kin Name: <Relationships>  Relationship to patient: <Relationships>  Tel No: <Relationships>  Are they the main carer?  Yes  No  If no, does the patient have another carer?  Yes  No Please provide contact name and details: |

**Medical Information-** Clinical print out attached  Yes  No

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| Diagnosis: | Does patient have Diabetes?  No  Yes -  T1 /  T2 | |
| Past Medical History: See below | Social History: | |
| Relevant medications: See below | Sip feeds/nutritional supplements: | |
| Relevant results: HbAlc: <Numerics> | Other results: | |
| Weight (kg): <Numerics> Height (m): <Numerics>  BMI (kg/m²):<Numerics> | Weight loss(in last 6 months): <Numerics> | MUST score (nutrition screening):  <Numerics> |
| Does the patient require a texture modified diet? | Y /  N Details: Food level:      Fluid level: | |
| Does the patient have any food allergies or intolerances: | Y /  N Details: | |
| Other comments: |  | |

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| **Medical Problems:**    <Problems>  <Summary> | |
| **Medication:** | |
| Acutes | <Medication> |
| Repeats | <Repeat templates> |
| **Allergies:**  <Allergies & Sensitivities> | |

**Reason for Referral**

Please indicate reason for referral below (to the left).

Additional information has been provided (on the right): These actions are optional to assist you and/or the patient in the interim (not all actions may be relevant to your role). Please indicate any points that are actioned.

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| **Reason(s) for referral** | | **Educational checklist** | | |
|  | Healthy eating | Provide BDA Food Fact Sheet on Healthy Eating <https://www.bda.uk.com/foodfacts/HealthyEating.pdf> | |  |
| Provide Are you having a nutritionally adequate diet?  <https://www.ruh.nhs.uk/patients/services/clinical_depts/dietetics/index.asp> | |  |
|  | Nutritional deficiency  Specify……………… | Provide BDA Food Fact Sheet on specific nutrients in food  <https://www.bda.uk.com/foodfacts/home> | |  |
|  | Advice to lose weight | Provide BDA Food Fact Sheet on Weight Loss <https://www.bda.uk.com/foodfacts/Want2LoseWeight.pdf> | |  |
| Provide link to ‘Food Portions’ section of BHF website or print sections  <https://www.bhf.org.uk/informationsupport/support/healthy-living/healthy-eating/healthy-eating-toolkit/food-portions> | |  |
| Ensure you have raised the issue of weight (Brief Intervention tool) | |  |
| Ensure you have completed a Primary Care Healthy Weight Assessment | |  |
| Refer to the Healthy Weight Pathway for BANES for appropriate referral | |  |
|  | Improving nutritional status/advice to gain weight | Provide Your Guide to Making the Most of Your Food <https://www.malnutritionselfscreening.org/pdfs/advice-sheet.pdf> | |  |
| MUST score ≥1 and not improving on food first advice consider ONS x2 per day *(powdered supplement if appropriate).* Refer to formulary.  <https://prescribing.wiltshireccg.nhs.uk/?wpdmdl=2070>  ***NB*** *For anyone requiring thickened fluids, do not prescribe supplement drinks before review by dietitian* | |  |
| If patient discharged from hospital on ONS, consider changing to powdered milkshake style, if appropriate. Refer to formulary.  <https://prescribing.wiltshireccg.nhs.uk/?wpdmdl=2070>  ***NB*** *For anyone requiring thickened fluids, do not make any changes to supplement drinks on prescription before review by dietitian (unless RUH dietitians have advised this)* | |  |
|  | Diabetes – **Type 1**  1:1 appointment | Signpost to Diabetes UK <https://www.diabetes.org.u>k | |  |
| Carbohydrate Counting Group | Signpost to Carbs and Cals website <https://www.carbsandcals.com> | |  |
|  | Diabetes – **Type 2**  X-PERT **Type 2 diabetes group** education.  (Where appropriate, refer patient to group, not 1:1 appt.) | You can refer to X-PERT group via Arden. For those unable to do so, use this form. | | |
| Signpost to Diabetes UK <https://www.diabetes.org.uk> |  | |
| **1:1** Type 2 diabetes appointment  (Request 1:1 only if group not appropriate.) | Signpost to Diabetes UK <https://www.diabetes.org.uk> |  | |
| Carbohydrate counting group | Signpost to Carbs and Cals website <https://www.carbsandcals.com> |  | |
|  | Food allergy/ intolerance | Provide BDA Food Fact Sheet on Food Allergies and Intolerances <https://www.bda.uk.com/foodfacts/Allergy.pdf> |  | |
| Provide BDA Food Fact Sheet on Food Allergy and Intolerance Testing  *(if patient requesting this)* <https://www.bda.uk.com/foodfacts/AllergyTesting.pdf> |  | |
|  | IBS  **TTG:** <Numerics> | Check TTG negative (on gluten containing diet) to rule out coeliac disease ***NB*** *Gluten should be consumed in more than one meal every day for at least 6 weeks before testing* |  | |
| Provide BDA Food Fact Sheet on Irritable Bowel Syndrome <https://www.bda.uk.com/foodfacts/IBSfoodfacts.pdf> |  | |
| Provide link to First Line Dietary Advice for IBS Webinar <https://patientwebinars.co.uk/ibs/ibs-webinars/> |  | |
| Provide information on BANES Talking Therapies *(if stress/anxiety is a factor)* <https://iapt-banes.awp.nhs.uk/> |  | |
|  | Coeliac disease  **TTG:** <Numerics> | Signpost to Coeliac UK website. Recommend membership. <https://www.coeliac.org.uk/home/> |  | |
| Provide link to relevant webinar:   * Newly Diagnosed Coeliac Disease / Review for Coeliac Disease * Calcium and Coeliac Disease   <https://patientwebinars.co.uk/coeliac/webinars/> |  | |
|  | Other: (please state)    <Event Details> | | | |

**Type of Intervention Required**

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| 1. Outpatient clinic   Location options: (please tick)  Paulton /  RUH /  St Martins /  Keynsham    *Group Education maybe offered for first line advice. If this is not suitable for this patient please state reason here:*     1. Telephone advice 2. Home visit   please indicate why home visit requested:  Housebound  Too unwell to attend outpatient appointment  Other: (please state)    *Please note that a home visit will only be carried out if deemed clinically necessary. Telephone advice may be*  *given if it is felt this would be appropriate. (Patients will not be seen at home purely due to transport difficulties).* |

**Referral Details**

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| Is an interpreter required?  Y  N  NA Details:  Are there any security/safety issues relating to seeing this patient?  Y  N  NA Details:  Has this referral been agreed with the patient?  Y  N  NA Details:  Is the patient motivated?  Y  N  Does the patient need to be accompanied to appointments?  Y  N  NA Details:      :  Does the patient have any difficulties with their mobility?  Y  N  NA Details:  Does the patient have capacity?  Y  N  NA Details:  Please indicate other services involved:  Consultant name:  Any other relevant information: |

**Referrer**

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| --- |
| Name of referrer: <Sender Name> Signature: <Sender Name> Date:<Today's date>  Referrer’s address:<Sender Details><Sender Address>  Contact telephone no: <Sender Details> Email address:<Sender Details>  (please provide contact details as we may need to clarify any information on this form)  Team: Community Neuro & Stroke Service  Reablement  Impact  Early Supported Discharge  GP surgery  District Nurses  Specialist Nurse  Learning Difficulties  Community matron  Other  ……………………………………………………Title:  Profession: Nursing  GP  Consultant  AHP  Other: |