**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.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

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| **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 |       |

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**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 [ ]  NoDoes patient consent to email correspondence? [ ]  Yes [ ]  NoDoes 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 [ ]  NoIf 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 deficiencySpecify……………… | 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 [ ]  NDoes 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:       |