**REFERRAL FORM FOR COMMUNITY NUTRITION AND DIETETICS SERVICES – MIDDLESBROUGH AND REDCAR AND CLEVELAND.**

**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 /  N  GP 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 /  N  Is 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 /  No  IF NO, refer to SALT first | |
| Reason for dietetic referral:  Diabetes - Group or Individual  Nutrition Support – complete sheet overleaf  Other: Specify details below  Pressure sore:  Yes /  No  Grade: | 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 questions  1. Are rings usually worn (such as wedding ring) a lot looser than they were 6 months ago:  Yes /  No  2. Have they dropped dress/trouser size in the last 6 months:  Yes /  No If yes provide details of original size and current size  3. 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 /  No  Have 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](mailto:ste-tr.guisboroughdietitians@nhs.net) | | |