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| **NHS No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Daytime Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male / Female** | | **GP/Consultant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Next of kin:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relationship to patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Contact number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Adults:**  Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MUST Score: \_\_\_\_\_\_\_\_\_  Date of Measurement:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous weights & dates: | **Children:**  Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Length: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Measurement:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Previous weights & dates: | **Has the patient given consent to this referral?**  **Yes No Unable**  **If unable, please state why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Clinic appointment**  **Housebound requiring home visit**  **Concerns about verbal or physical abuse**  **Any relevant information for home visit eg. animals of concern, gaining access\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Reason for Referral:**  **Assessment for nutritional deficiencies**  **MUST Score >2**    **Dysphagia -referred to SALT Y / N**  **Pressure wound – Grade \_\_\_\_\_\_\_**  **Reduced oral intake due to cancer treatment**  **Enteral feeding:**    **Feeding route eg. NG/PEG \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Food allergy Intolerance**  **To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Non IgE medicated allergy only**  **IBS – no improvement after first line advice**  **Protein Energy Malnutrition under 18 years**  **f Faltering Growth/Low BMI**  **Coeliac disease**    **Other Gastro condition – please specify: \_\_\_\_\_\_\_\_\_\_\_**  **Is this referral related to military service?** | | **Diagnosis and relevant medical history:** |
| **Medication / Nutritional supplements / Feed:** |
| **Relevant biochemistry:** |
| **Are there diagnosed psychological illnesses?**  **Yes Please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **No** |
| **Communication needs due to disability / sensory loss**  **Yes**  **No** |
| **Interpreter required?**  **Yes**  **No** |

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| **Please note we do not accept referral for the following:**   * Eating disorders – Anorexia Nervosa, Bulimia, ARFID, Binge Eating Disorder * Metabolic disorders managed by secondary care * Multiple food allergies. IgE medicated reactions * Malnutrition with unmanaged depression * Weight Management. Please use SWMS referral criteria for local services * Diabetes. Please refer to X-pert for new diagnosis and poor compliance * CKD above Stage 3   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **We follow an opt-in process for appointments. If you feel this will be difficult for the patient, please advise below:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Base: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Any other relevant information:**  **Please email completed referral form to tspoa1@nhs.net** |