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| **Service required:**  Community Nutrition and Dietetic Service – Adults and children Weight management – Children and YP (CWMS)  Community Neuro Rehab Dietitian Weight management – Adult Specialist Weight  (For X-pert Diabetes Programme use X-pert ref form on EMIS) Management MDT (SWMS) | |
| **NHS no**. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Postcode**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Day time Tel No**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Male/Female** | **GP/Consultant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** |
| **ADULTS**  Wt: \_\_\_\_\_\_\_ Ht: \_\_\_\_\_\_\_\_\_ BMI:\_\_\_\_\_\_\_\_\_\_  Weight loss in past 3 mths \_\_\_\_\_ % 6 mths \_\_\_\_\_\_%    MUST Score (adults)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **CHILDREN**  Wt: \_\_\_\_\_\_\_ Ht : \_\_\_\_\_\_\_\_\_:BMI \_\_\_\_\_\_\_\_\_\_  Date of Measurement \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Next of Kin:** |
| **Reason for referral:** | **Medication/Nutritional supplements or feed:** |
| **Relevant Biochemistry:** | **CARE HOMES ONLY- please supply copy of MARS sheet**  Food/Fluid diary in place + send 3 days with referral  Fortified diet provided / Chef informed  Snacks / Milky drinks between meals  Over the counter or homemade fortified drink (containing >/300kcal+10g protein)BD for at least 4 weeks prior to referral**.** |
| **Relevant Medical History/Diagnosis** | **Are there any diagnosed psychological illnesses? Yes/No**  If yes, please state….. |
| **Other Services involved e.g. carers, social services** | **Communication needs due to disability/sensory loss? Yes/No**  If yes, please state….  **Interpreter required? Yes/No**  If yes, which language.... |
| **Is patient from BAME group? Yes/No** |
| **Lone Worker:**  Any incidents involving the patient and verbal or physical abuse to staff? **Yes/No**  **If yes, please give details…..** | |
| **Does the patient require transport? Yes/No**  **Is patient housebound therefore requiring home visit? Yes/No**  Please give relevant info e.g. Animals of concern, gaining access, manual handling, infection control issues... | |
| **REFERRED BY:**  **Print Name: Designation:**  **Signed: Base:**  **Date: Telephone:**  **Email:** [**tspoa1@nhs.net**](mailto:tspoa1@nhs.net) **with read receipt, or post to: Trafford Single Point of Access, George Carnall Leisure Centre, Kingsway Park, Urmston, Manchester, M41 7FJ Tel: 0300 323 0303** | |