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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 informedSnacks / Milky drinks between mealsOver 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** **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** |