|  |  |
| --- | --- |
| **NHS no**. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Postcode**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Day time Tel No**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Male/Female** | **GP/Consultant**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Next of kin:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relationship to patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Contact number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **MUST Score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Weight loss in last 3-6 months: \_\_\_\_\_\_\_\_\_\_ kg**  **Date of Measurement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Has the patient given consent to this referral?**  **Yes No Unable**  **If unable to consent, reason why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **If unable to consent, who is providing consent for referral?** |
| **Last 3 weights or MUAC**  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **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**  **Coeliac disease**    **Other Gastro condition – please specify: \_\_\_\_\_\_\_\_\_** | **Is this referral related to military service?**  **Diagnosis and relevant medical history:** |
| **Medication:** |
| **Relevant biochemistry:** |
| **Are there diagnosed psychological illnesses?**  **Yes Please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **No** |
| **Communication needs due to disability/sensory loss**  **Yes Please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **No** |
| **If completed by a non-health professional, has the GP been informed and supports this referral?**  Yes No ( if no, please consult GP before referral as this will result in the referral being declined) | |

|  |
| --- |
| For patients referred for malnutrition (MUST score >2), please confirm that the following is in place:  Treat underlying condition  Record need for special diet  Optimise times when appetite is good  Offer snacks and fortified milky drinks in between meals  Document dietary intake for 3 days (food record chart) and review  Liaise with catering staff and instigate high protein, high calorie diet  Offer “over-the-counter” Meritene/Complan/Aymes/Foodlink Complete drinks twice a day, or a fortified homemade supplement drink containing approximately 300kcal and 10g protein (see nourishing drinks leaflet).  Weight and screening completed weekly  **All of the above have been carried out for 4 weeks with no improvement, before making this referral. You will be asked to provide evidence of this on assessment.** |
| Is the resident prescribed nutritional supplements?  Yes No  If yes, what are they prescribed?  Are they taking them? Yes No  On average, how much of a meal does the patient eat? (ie. ¼, ½, ¾ or all): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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 |
| Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Base: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Please add any other relevant information:**  **Please email completed referral form to Trafford Single Point of Access (SPOA):** [**tspoa1@nhs.net**](mailto:tspoa1@nhs.net)  If you need to check referral has been received please telephone SPOA directly on: **0300 323 0303** |