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| **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 last 3 months \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****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) |

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| 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 dietOffer “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
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| 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**If you need to check referral has been received please telephone SPOA directly on: **0300 323 0303** |