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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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Adults**Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MUST Score: \_\_\_\_\_\_\_\_\_\_Date of Measurement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Children**Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Length: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Measurement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **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: \_\_\_\_\_\_\_\_\_\_\_\_\_** | **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 Please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****No**  |
|  | **Communication needs due to disability/sensory loss****Yes Please state \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****No** **Interpreter required****Yes Language required \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****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

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