 Bexley Community Dietetic Service - Adults

Referral form for Nursing/Care Home Staff please email to bromh.cccpod2refs@nhs.net

Community Dietitians ,St Paul’s Cray Clinic, Mickleham Road, St Paul’s Cray, Orpington BR5 2RJ **Tel: 0300 330 5777**

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| **PATIENT DETAILS** | **REASON FOR DIETETIC REFERRAL**  |
| **Name** |  | **MUST Score 2 or more** |  |
| **Date of birth** |  | **Other:** specify e.g. pressure sore, modified diet, GI condition |
| **Gender** |  |
| **Home****Address** |  | **Advice for unintentional weight loss which must be actioned for at least 1 month pre referral.** |
| **Postcode** |  |  |
| **Tel No** |  |
| **Ethnicity** |  |
| **NHS No** |  |
| **GP DETAILS** | **NUTRITIONAL SUPPLEMENTS** |
| **GP** |  | **Patient on Nutritional supplements?** |  |
| **Surgery** |  | **Name** |  |
| **Address** |  | **Dose** |  |
| **Postcode** |  | **Starting date** |  |
| **Tel No** |  | **Tolerance** | [ ]  Yes [ ]  No |
| **Fax No** |  | **Compliance** | [ ]  Yes [ ]  No |
| **RELEVANT CONCERNS** | **RELEVANT MEASUREMENTS** |
| **Bowel type:** |  | **Height :** | **Date:** |
| **Pressure ulcer**location and grade  |  | **Current Weight :** | **Date:** |
| **Swallowing difficulties** |  | **BMI :** | **Date:** |
| **Is patient on thickened fluids? –** Specify stage/level |    | **MUST Score number:** | **Date:** |
| **Is patient on texture modified diet? -** Specify | [ ]  No [ ]  1 [ ]  2 [ ]  3 | **Weight history for past 6 months:** (Please provide monthly weights with full date) |  |
| **MEDICAL DIAGNOSIS/PMH & MEDICATION** | **RELEVANT SOCIAL INFORMATION** |
| Has the patient been referred to the Bexley [ ]  Yes [ ]  NoCommunity SLT for swallowing difficulties?Please attach the following: prescription list, any recent blood results and food and fluid chart (one week).  |  |
| **OTHER PROFESSIONALS INVOLVED** |
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| **Referrers Name & Job Title**  |  | **Date** |  |