 Bexley Community Dietetic Service - Adults

Referral form for Nursing/Care Home Staff please email to [bromh.cccpod2refs@nhs.net](mailto: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  No  Community SLT for swallowing difficulties?  Please attach the following: prescription list, any recent blood results and food and fluid chart (one week). | | | | |  | | | | | | | |
| **OTHER PROFESSIONALS INVOLVED** | | | | | | | |
|  | | | | | | | |
| **Referrers Name & Job Title** | | | |  | | **Date** | | | |  | | |