Adult Dietetics Referral Form

# Tel 0151 604 7271 Fax 0151 514 2232 or Email us on [wchc.dieteticsadult@nhs.net](mailto:wchc.dieteticsadult@nhs.net)

# Please ensure the form is fully completed and attach patient summary.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Title: | | | | | First Name: | | | | | | | | | | | | | | | | | | | | | | | | | Surname: | | | | | | | | | | | |
| Is the patient in a Nursing Home? | | | | | | | | | | | | | | | | | | | | | | | Yes | | |  | | | No | | | |  | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | Date of Birth | | | | | | | | | | |  | | | | | | | | | | | |
| NHS Number | | | | | | | | | | |  | | | | | | | | | | | |
| Home No: | | |  | | | | | | | | | | | | | | | | Mobile No: | | | | | | | | | | |  | | | | | | | | | | | |
| Preferred Contact | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referrer & Contact No. | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GP Name: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Practice/Hospital name | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Practice /Hospital Address | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the patient Palliative? | | | | | | | | | | | | | | | | | | | | | | | Yes | | | |  | | | | No | | | | | |  | | | | |
| Is the patient Housebound? | | | | | | | | | | | | | | | | | | | | | | | Yes | | | |  | | | | No | | | | | |  | | | | |
| Height | |  | | | | | Date | | | | | | |  | | | BMI | | | | | | | | | |  | | | | | | | Date | | |  | | | | |
| Current Weight | |  | | | | | Date | | | | | | |  | | | | **Previous Weights (at least 2)** | | | | | | | | |  | | | | | | | Date | | |  | | | | |
| Medication (or attach patient summary) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical History (or attach patient summary) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for Referral | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type 2 Diabetes | | | |  | | | | | Lipid Lowering | | | | | | | | | | | | |  | | Nutritional Support (see below) | | | | | | | | | | | | | | | |  | |
| Impaired Glucose | | | |  | | | | | Other – please specify | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| **If Diabetes / IGT / Lipids please give relevant blood results as per WHO criteria.**  (please note Type1 Diabetes is usually referred to specialist hospital dietitian. ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fasting plasma glucose |  | | | | | 2 hour plasma glucose | | | | | | |  | | | | | | | Hba1c | | | | | | |  | | | | | | | | Date | | | |  | | |
| HDL |  | | | | | LDL | | | | | | |  | | | | | | | Triglycerides | | | | | | |  | | | | | | | | Date | | | |  | | |
| Other Info |  | | | | | | | | | | | | | | | | | | | | **Date of Diagnosis of Diabetes** | | | | | | | | | | | | | | |  | | | | | |
| If Nutritional Support select reason(s) why. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Very Rapid Weight loss (more than 10% in a month) | | | | | | | | | |  | Gradual weight loss and/ or low BMI (14-18.5) | | | | | | | | | | | | | |  | | | Weight stable but slightly low BMI (18.5-19.9) | | | | | | | | | | | | |  |
| Very Low BMI (Less than 14) | | | | | | | | | |  | Weight stable, supplements stopped waiting assessment,or GP wishes to stop. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| MUST Score. | | | | | |  | | | | | | | | | | | | | | Other, please specify | | | | | | | | | | | | | | |  | | | | | | |
| Pressure Ulcer | | | | | | | | | | | | Yes | | |  | No | | | | |  | | | Grade (1-5) | | | | | | | | | | | | |  | | | | |
| Any known Risk Factors To staff | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the patient appropriate for group education? | | | | | | | | | | | | | | | | | | | | | | | Yes | | | |  | | | | | No | | | | | |  | | | |
| Is a translator required? (if Yes Language) | | | | | | | | | | | | | | | | | | | | | | | Yes | | | |  | | | | | No | | | | | |  | | | |
| Does the patient suffer from Dementia/Delirium? | | | | | | | | | | | | | | | | | | | | | | | Yes | | | |  | | | | | No | | | | | |  | | | |

# Incomplete or illegible forms will be returned to the referrer leading to a delay in the patient being seen.