Dietetic Service (Adults) Referral Form *(Version 9 March 25)*

Date of referral……………………………………….

Please complete all sections of the form marked with an asterisk (\*) or the form

will not be processed and returned to the referrer.

Has the patient consented to this referral? Yes  Or If the patient lacks capacity, please indicate if this referral is being made in the patient’s best interests:  *(please mark as appropriate).*

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| \*PATIENT DETAILS  Name: Patient Landline Tel. No.:  D.O.B: Patient Mobile Phone No.: NHS Number: Preferred Contact Details if Different to Patient: **Patient Address and Post Code: Registered GP Practice:** |
| \*REFERRED BYName: Designation: Service: Tel. No.: |
| EXCLUSION CRITERIA  * **Individuals requiring weight management (Obesity) support:** * *For patients with BMI >40kg/m2 or BMI >35kg/m2 with comorbidities please refer to the Tier 3 Weight Management Service 01226 644364 option 1 / ext. 4365 or via the electronic link:* [*Barnsley tier 3 weight management service - South West Yorkshire Partnership NHS Foundation Trust*](https://www.southwestyorkshire.nhs.uk/services/barnsley-tier-3-change4life-weight-management-service/) * *For patients with BMI 25kg/m2 – 40kg/m2 please consider accessing Health and Wellbeing Coach support via the patient’s GP Practice.*      * **Individuals being referred for dietary advice for Diabetes:** * *Should initially be referred to the Barnsley Hospital Diabetes Service via the following email address* [*BarnsleyDiabetes.SPA@nhs.net*](mailto:BarnsleyDiabetes.SPA@nhs.net) *or via 01226 240 086 who may onward refer to this service in due course dependent on the support required.* * **Individuals with eating disorders:** * *Referrals for the treatment of eating disorders are not accepted by the service. Please consider signposting to the Soutth Yorkshire Eating Disorder Association.* * **Individuals with a recent stroke diagnosis with a stroke-related nutritional problem:** * *Should be referred to the Barnsley Community Stroke Team via the email:* [*BarnsleyCommunity.StrokeTeam@swyt.nhs.uk*](mailto:BarnsleyCommunity.StrokeTeam@swyt.nhs.uk) * **Individuals with a learning disability diagnosis who have a nutritional problem:** * *For individuals with a Learning Disability who require dietetic support and are unable to access mainstream services, please refer to the Barnsley Community Learning Disability Team via the email* [*Barnsley.LD.Duty@swyt.nhs.uk*](mailto:Barnsley.LD.Duty@swyt.nhs.uk) *or 01226 645237.* * **Individuals who are currently under the care of a Paediatrician, please use the Paediatric referral form for this cohort.** |
| \*INCLUSION CRITERIA *(please tick the reason for referral, failure to specify will result in the referral being rejected):* **Nutrition Support (underweight, undernourished, unintentional weight loss).**  **Diabetes *(Please note we do not accept direct referrals for Diabetes. Referrals must be made via the Barnsley Hospital Diabetes SPA).***  **Gastro-related conditions (e.g. IBS / IBD / Coeliac Disease).**  **Enteral Tube Feeding (e.g. PEG, NG, NJ) *(Please provide details of feeding regime in the ‘Reason for Referral’ section of this form, refer to guidance notes for further information).***  **Dietetic Assessment (including symptom management).** |
| **REASON FOR REFERRAL *(Please provide all relevant information relating to this referral. For guidance please see the notes at the bottom of this page).*** |
| **\*PATIENT WEIGHT DETAILS** ***(Please ensure that a figure is provided or if not available then a valid reason provided for the absence of this information otherwise the referral will be rejected).***  **Height (m):**  **Current weight (kg):(date):**  **Current BMI (kg/m2):**  **Previous weights (with dates):** |
| **\*MEDICAL HISTORY** |
| **\*MEDICATION *(Please include details of any prescribed nutritional supplements):*** |
| **ADDITIONAL INFORMATION**  **Interpreter / Signer Required: Yes  No  Language:**  **Is the patient able to communicate over the telephone: Yes  No**  **Is the patient able to attend a clinic appointment:**   **Yes  No** |

**Guidance notes, please note, these are not exhaustive and intended to support the referrer to provide sufficient necessary relevant information.**

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| **Reason for referral** | **Additional information** |
| **Nutrition Support** (underweight, undernourished, unintentional weight loss) | * *Please provide up to date weight and BMI (or reason why not available)* * *Weight history within last 3-6 months (or reason why not available)* * *Details of any oral nutritional supplements currently prescribed/recently tried* * *Any relevant information regarding dietary intake e.g. swallowing problems, texture modified diet and fluids, social factors, receiving palliative care, skin integrity/pressure injury* |
| **Gastro-related conditions** | * *For IBS, please confirm red flags have been excluded* * *Please provide details of any relevant tests and investigations e.g. relating to coeliac disease, IBS, IBD* |
| **Enteral Tube Feeding** | * *Please provide details of feeding regime, type and size of tube, date of tube placement and details of training completed.* |