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 BY  Name: 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* *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*
* **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* *or 01226 645237.*
* **Individuals who are currently under the care of a Paediatrician, please use the Paediatric referral form for this cohort.**
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| \*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*
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| **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*
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| **Enteral Tube Feeding** | * *Please provide details of feeding regime, type and size of tube, date of tube placement and details of training completed.*
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