Dietetic Service (Paediatrics) Referral Form *(Version 4 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 / legal guardian consented to this referral? Yes  No  *(please mark as appropriate).*

|  |
| --- |
| \*PATIENT DETAILS  Name: Patient Telephone No.:  D.O.B: Parent / Carer Name: NHS Number: Parent / Carer Telephone No.:Patient Address and Post Code: Relationship to Child:   **Patient’s Registered GP Practice:** |
| \*REFERRED BYName: Designation: Service: Tel. No.: |
| EXCLUSION CRITERIA  * **Children requiring weight management support.** * *Please refer to T3 Weight Management Service 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/) * **Children with eating disorders.** * *Referrals for the treatment of paediatric eating disorders are not accepted by the service. Please refer to Branching Minds via the email:* [*BarnsleyCYPMHRequestSupport@swyt.nhs.uk*](mailto:BarnsleyCYPMHRequestSupport@swyt.nhs.uk) * **Children with suspected or confirmed IgE allergy / complex or multiple food allergy.** * *Please refer to Barnsley Hospital Paediatric Allergy Clinic.* * **Children with diabetes.** * **Children with an enteral feeding tube.** * *Please refer to the Barnsley Hospital Paediatric Dietitians via the email:* [*barnsleypaed.diet@nhs.net*](mailto:barnsleypaed.diet@nhs.net) *unless aged 16 plus and are no longer under the care of a Paediatrician and have transitioned to Adult Services.* |
| \*INCLUSION CRITERIA *(please tick the reason for referral, failure to specify will result in the referral being rejected):* **Faltering Growth.**  **Gastro-related conditions (e.g. IBS / coeliac disease / constipation).**  **Cow’s Milk Protein Allergy.** (**Please confirm diagnosis before referring for dietetic support).**  **Food Allergy / Food Intolerance (other than cow’s milk protein allergy).**  **Selective Eating (please note we do not provide feeding therapy).**  **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 form).*** |
| **ARE THERE ANY SAFEGUARDING CONCERNS?**  Yes  No  *(please mark as appropriate, if yes please provide further details below).*  **Details:** |
| **\*ANTHROPOMETRIC MEASUREMENTS: *(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).***   |  |  |  |  | | --- | --- | --- | --- | | Date of measurement | Weight (kg) Centile | Height / Length (cm) Centile | BMI Centile (children over 2 yrs) | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **\*MEDICAL HISTORY** |
| **\*MEDICATION *(Please include details of any prescribed nutritional supplements):*** |
| **ADDITIONAL INFORMATION**  **Interpreter / Signer Required: Yes  No  Language:**  **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.**

|  |  |
| --- | --- |
| **Reason for referral** | **Additional information** |
| **Faltering Growth** | * *Please provide up to date weight, height / length and BMI (or reason why not available).* * *Please detail any centile changes and ensure weight and height/length history is provided.* |
| **Gastro-related conditions** | * *For functional gut disorder, please confirm red flags have been excluded.* * *Please provide details of any relevant tests and investigations e.g. relating to coeliac disease, IBS.* |
| **Cow’s milk protein allergy** | * *Please confirm diagnosis* ***before*** *referring for dietetic support. See* ***BARNSLEY GUIDANCE ON THE MOST APPROPRIATE AND COST EFFECTIVE PRESCRIBING OF INFANT FORMULA IN PRIMARY CARE Appendix 1: Initial Assessment and Diagnosis of Suspected Cow’s Milk Protein Allergy (CMPA) in Infants*** [***Infant\_Formula\_Guidelines.pdf (barnsleyccg.nhs.uk)***](https://best.barnsleyccg.nhs.uk/clinical-support/medicines/prescribing-guidelines/Infant_Formula_Guidelines.pdf)   *Please provide reason if not able to confirm diagnosis.*   * *Please provide details of symptoms.* * *Please state if breast or formula feeding and details of any formula being prescribed.* |
| **Food allergy/food intolerance other than cow’s milk protein allergy** | *Please include details of:*   * *symptoms (duration, severity).* * *any suspected foods.* * *Please confirm that red flags and other potential medical causes have been excluded first before referring.* |
| **Selective eating** | * *Please provide as much detail as possible regarding foods/food groups that are accepted and refused.* * *Please ensure weight and height history is included.*   ***Please note that we do not provide feeding therapy.*** *Patients will have a dietetic assessment with individualised dietary advice to optimise nutritional intake with the aim of preventing nutritional deficiency and achieving satisfactory growth.* |