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).*

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| --- |
| \*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 BY  Name: 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*
* **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* *unless aged 16 plus and are no longer under the care of a Paediatrician and have transitioned to Adult Services.*

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| \*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) |
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| **\*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.*
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| **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.*
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| **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.*
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| **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.* |