

HENS REFERRAL FORM

Please complete the details below and return this referral form to the Home Enteral Nutrition Team (HENS)

PLEASE NOTE: Incomplete forms may be returned

Hospital:	Ward:	Ward Ext No:	Ward Dietitian:	Ward Dietitian Tel No:
Patient Sticker:		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Hospital Consultant (Include initials & speciality):
NHS Number:		GP Details (Include initials, address, post code & telephone number):		
Surname:				
Forename:				
Address:				
Postcode:	Lives alone: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Birth:				
Landline Telephone Number:				
<input type="checkbox"/> Preferred Number? Mobile Telephone Number: <input type="checkbox"/> Preferred Number?				
Discharge Destination:			Communication Difficulties:	
Name of Carer/Care Agency/Care Home:			Preferred language:	
Telephone Number:				
Confirm patient has agreed to be contacted about enteral feeding at home: Yes / No				
Any safety concerns with a lone home visit? Yes / No (list below):				
Interpreter needed: Yes / No				
Any safeguarding concerns: Yes / No (please state):				
Name/s & relationship/s of person/s that need training by HENS (include telephone number/s):			Date Tube Sited:	
Have they agreed to be trained: Yes / No			Enteral Feeding Route (please tick):	
			<input type="checkbox"/> PEG <input type="checkbox"/> RIG <input type="checkbox"/> NG <input type="checkbox"/> NJ <input type="checkbox"/> Jejunostomy <input type="checkbox"/> Other (list below)	
Weight History (include dates):			Manufacturer/Size:	
Height:			Allergies:	
Current BMI:				

PLEASE TURN OVER.....

Diagnosis/Treatment:

Past medical history:	
Infection Prevention Alert (e.g. CRO, C-DIF, MRSA):	
Aim of Dietetic Treatment (e.g. Pre Operation Build Up):	
Current Feeding Regimen/Method of feeding:	<input type="checkbox"/> Bolus <input type="checkbox"/> Pump <input type="checkbox"/> Both
Bowel habits:	Feed tolerance issues:
Swallowing ability, oral intake, SALT involvement:	NBM <input type="checkbox"/> YES <input type="checkbox"/> NO
Relevant Medications:	
Other relevant information:	
Proposed date of discharge:	Date of referral:
Print name:	
PLEASE update the HENS team regarding any significant changes to the information on this form by email (NOT by sending a second referral form).	

By post: Leicestershire Nutrition and Dietetic Service, Home Enteral Nutrition Service (HENS), OSL House, East Link, Meridian Business Park, Leicester LE19 1XU Tel: (0116) 2227161

By email from UHL/LPT: Hens@Inds.nhs.uk

By email from external Trusts: Hens.Team@nhs.net