Leicester, Leicestershire and Rutland
Area Prescribing Committee

Care-Home-to-Dietetics Direct Referral Form

Leicestershire Nutrition and Dietetic Service, OSL House, East Link, Meridian Business Park, Leicester, LE19 1XU. Contact number: 0116 222 7170

Please note this form for direct referral to Leicestershire Nutrition and Dietetics Service (LNDS) is ONLY for patients requiring nutrition support advice in relation to malnutrition, who meet referral criteria after following the **LLR Management of Malnutrition in Care Homes pathway**.
For all other dietetic referral requests, please ask the patient's GP to refer in line with **LNDS Adult referral criteria**.
If you are experiencing issues accessing this document, please email **lpt.dietitiansphcadmin@nhs.net**.

PLEASE NOTE:

- **All questions (pages 1-3) on this form must be answered**
- **Copy of current MAR chart must be included with each referral**
- **3 days detailed food and fluid record charts must be included with each referral**

Please **email** completed pages **with** 3 days detailed food and fluid record charts **and** a copy of current MAR to: lpt.dietitiansphcadmin@nhs.net

1) Referrer's Details:			
Date of Referral:		Care Home:	
Referrers Name:		Address:	
Referrers Job title:		Contact number:	
Care home e-mail address for communication:			

2) Resident's Details:			
Resident's full Name:		GP name and address:	
Date of Birth:			
NHS number:			

3) Pre-Referral checklist			
Is the resident at HIGH risk of malnutrition (assessed via a MUST screening tool)			
Yes		No	
Have meals been fortified every day for at **least 1 month**?			
Yes		No	
Have nourishing snacks been offered twice a day for at **least 1 month**?			
Yes		No	
Have homemade supplements been offered twice a day for at **least 1 month**? (**unless**: 1. patient meets exclusion criteria OR 2. Patient is on prescribed ONS OR 3. Further guidance from dietitian required before starting home-made replacement drinks -see note below)			
Yes		No	

Please Note: If you have answered 'no' to any of the above questions, please do not refer to the Dietitians, and instead please visit the **LLR Care Home Management of Malnutrition Pathway** and ensure this has been followed thoroughly before considering a referral to Dietetics.

HOWEVER,

- ☐ **if any of the exclusion criteria is met, OR**
- ☐ **the resident is on prescribed oral nutritional supplements (ONS) and is not currently under a dietitian, OR**
- ☐ **further guidance is required**

then please complete this referral.

Date of preparation	Date of last review	Date of next review	Approved by LLR APC	Version
June 2025	August 2025	August 2028	August 2025	V1

4) Reason for Referral: (please select)

- Exclusion criteria met – **if yes please provide further details:**
  OR
- Resident is on prescribed oral nutritional supplements (ONS) and is not currently under a dietitian
  OR
- Further guidance is required from dietitian before starting home-made replacement drinks- **if yes please provide further details of clinical condition/factors which require further guidance/support with:**
  OR
- Food based treatment has been in place for 1 month, but patient has not made any improvements
- **Other: Please provide further details:**

Past Medical History:
Allergies or intolerances:
Dietary Preferences: (e.g. resident is following a vegan diet/halal diet/lactose free)

5) Weight/MUST Score:

Most recent Weight:		Date weight taken:	
Current Height:		Current BMI:	
Current MUST score:			

Please provide the last 6 months weights (and dates taken) below:

Weight:		Date:		Weight:		Date:	
Weight:		Date:		Weight:		Date:	
Weight:		Date:		Weight:		Date:	

***Please note:** If you are unable to weigh the resident, please fill in the above information using their **MUAC measurements** instead of weights.

***Useful Tip:** If a resident's weight has dropped significantly in 1 month, or their MUST score has increased from 0-2 in one month, please consider re-checking weight and re-calculating MUST to ensure this is accurate.

6) Weight details:

If the resident has **lost weight**, have you notified the GP and made them aware of any nutritional concerns**?**

Yes		No	

If the resident has **lost weight**, did anything happen at the time of **weight loss?**

No ☐	Hospital admission ☐	Chest infection/UTI ☐	Vomiting/ Diarrhoea ☐	Other ☐ Please State:

If you have selected any option other than 'no' above, please specify if this issue has resolved or is ongoing (if applicable)?

Resolved		Ongoing	

Does the resident currently have **oedema** (fluid swelling in legs/feet)?

Yes		No	

Does the resident take **diuretics** (water tablets) for this oedema?

Yes		No	
Has this **dose/medication** recently been changed?			
Yes		No	
Did the resident recently have **oedema** which has now gone?			
Yes		No	

7) Swallowing difficulties:

Does the resident have a modified texture diet or thickened fluids?			
Yes		No	
If yes, why does the resident have a **modified texture diet or thickened fluids**?			
SLT advice (because of diagnosed swallowing difficulty) + resident wishes to follow this advice ☐	Resident requested it ☐	Other health professional advice ☐	
If yes, What IDDSI level **food** is the patient currently on:		If yes, What IDDSI level **fluid** is the patient currently on:	
Please specify the date that current IDDSI food level was put in place:		Please specify the date that current IDDSI fluid level was put in place:	

8) Oral Nutritional Supplements:

Does this resident currently have Oral Nutritional Supplements (ONS) prescribed?			
Yes		No	
If yes, please outline any prescribed ONS below, with doses:			
Has this resident previously been prescribed ONS in the last 6 months?			
Yes		No	
If yes, please state the date when these ONS were stopped below:			