Leicestershire Nutrition and Dietetic Services

DIETETIC REFERRAL FORM – COMMUNITY HOSPITALS

Please note this form should be left on the ward, or in a location agreed locally, for your dietitian to collect.

Please leave a message on your dietitian's answerphone if the referral is URGENT

FROM: Hospital …….

Ward ……Tel No …… FAX……..

<table>
<tr><td>DATE OF REFERRAL:</td><td>NHS NO.</td><td colspan="2">PATIENTS SURNAME: FORENAME/S:</td></tr>
<tr><td colspan="2">REFERRERS NAME & CONTACT DETAILS:</td><td colspan="2">PATIENT ADDRESS:

POST CODE:</td></tr>
<tr><td colspan="2" rowspan="2">GP DETAILS:</td><td rowspan="2">DATE OF BIRTH:</td><td>SEX: M / F</td></tr>
<tr><td>ETHNICITY:</td></tr>
<tr><td colspan="2">SPECIAL REQUESTS: (e.g. Language/interpreter)</td><td>RECENT BP:</td><td>WEIGHT</td></tr>
<tr><td colspan="2" rowspan="2">REASON FOR REFERRAL:
Please give justification when NST <15 or else referral may be deemed inappropriate.</td><td>BMI:</td><td>NST SCORE:</td></tr>
<tr><td colspan="2">RELEVANT TEST RESULTS FOR REFERRAL e.g.

LIPIDS……

HBA1c……...

Other relevant Biochemistry……..</td></tr>
<tr><td colspan="4">ACTIONS ALREADY IMPLEMENTED:

3 Day Food Record Chart ☐ Milky Drinks ☐ Build up soups/shakes ☐

High calorie snacks ☐ Other: (Please specify)……..</td></tr>
<tr><td colspan="4">RELEVANT MEDICATION e.g. for diabetes, weight management, lipid control</td></tr>
<tr><td colspan="4">RELEVANT MEDICAL/SOCIAL HISTORY:</td></tr>
<tr><td colspan="4">DIET SUGGESTED:</td></tr>
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