**CYPFND Paediatric Home Enteral Feeding REFERRAL FORM**

**Please complete and send to:** CYPFND Team (**mailbox.CYPFND@berkshire.nhs.uk****)** Office Tel Number: **0118 207 0932**

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| --- |
|  **REFERRAL TYPE**  |
| [ ] **RETAINING DIETETIC CARE** **Please complete SECTION 1. No need to complete SECTION 2. Only complete SECTION 3 if required** | [ ] **TRANSFER of DIETETIC CARE** **Please complete SECTIONS 1 AND 2.** **Only complete SECTION 3 if required** |
| **SECTION 1 (Please complete for BOTH TRANSFER and RETAINING of dietetic care referrals)** |
| **PATIENT INFORMATION** | **REFERRAL DETAILS** |
| **Full Name:** |  | **Date of Referral:** | Click or tap to enter a date. |
| **DOB:** |  | **NHS Number:** |  | **Name of Referrer:** |  |
| **Address:** | **GP Name/Address:** | **Job Title:** | **Place of work:** |
|  |  |  |  |
| **Contact Telephone Numbers:** | **Email Address:** |
|  |  |
| **Contact telephone Number:** | **Ethnicity:** | **Date of Discharge:** | **Number of Days TTOs:** |
|  | Please select  | Click or tap to enter a date. | Choose an item. |
| **MEDICAL HISTORY/DIAGNOSIS** | **MEDICATIONS (including dosage/frequency)** |
|  |  |
| **Immunocompromised:** | [ ]  Y [ ]  N |
| **ENTERAL FEEDING TUBE** | **OTHER INFORMATION** |
| **Reason for enteral feeding:** | **Named CCN:** | **Named Comm Paediatrician:** |
|  |  |  |
| **Please note we are unable to accept patients without a named Comm Paed/CCN.** |
| **Make/Type:** | **Size:** | **GP Prescription Request sent and attached with referral form:** |
|  |  | [ ]  Y [ ]  N (required unless OTC feed or BD etc) |
| **Hospital Placed:** | **Date Placed:** | **Abbott Hospital 2 Home Account:** |
|  | Click or tap to enter a date. | Transferred to BHFT: |  [ ] Y [ ] N | DeliveryMade: |  [ ] Y [ ] N |
| **Is this patient Jejunal fed:** | [ ]  Y [ ]  N | **Please ensure you follow the** **BHFT Paediatric Ancillary Guide when setting up Abbott H2H accounts. Link** [**https://cypf.berkshirehealthcare.nhs.uk/media/109514348/berkshire-healthcare-ancillary-guide-2022-final-220322.pdf**](https://cypf.berkshirehealthcare.nhs.uk/media/109514348/berkshire-healthcare-ancillary-guide-2022-final-220322.pdf) **If you do not have access to Abbott H2H, please provide details of plastics/ancillaries required in SECTION 3** |
| **SECTION 2 (Please complete for TRANSFER of dietetic care referrals ONLY)** |
| **ANTHROPOMETRICS AND NUTRITIONAL INFORMATION** |
| **Measurements (Current and Previous Hx including Date /Weight /Length or Height/ Centile):** |
|  |
| **Other information (ie usual weight):** | **Estimated Nutritional Requirements:** |
|  |  |
| **Feed Tolerance (****e.g. hx of vomiting, diarrhoea, reflux, intolerance of other feeds):** | **Allergies:** |
|  |  |
| **SLT Advice/Swallow Assessment:** |
|  |
| **Oral intake information:** | **Estimated Nutritional Oral Intake** |
|  | **Energy** | **Protein** | **Fluid** |
| **ENTERAL FEEDING PLAN (Please either complete below or send a copy of the feed plan with the referral form)** |
| **Current Feed Plan (Start Time/ Rate/ Water flushes/ Feed Name/ Volume/ Feed Duration):** |
|  |
| **SECTION 3 (Please complete WHERE REQUIRED for TRANSFER and RETAINING of dietetic care referrals)** |
| **ENTERAL FEEDING SUPPLIES:** |
| **If no access to Abbott Hospital2Home, please indicate plastics/ancillaries required for this patient using the \*BHFT Paediatric Ancillary Guide.** |
| **Product**  | **Quantity** | **Product**  | **Quantity**  | **Product**  | **Quantity**  | **Product**  | **Quantity**  |
| 1ml syringes |   | 2.5ml syringes |  | 3ml syringes |  | 5ml syringes |  |
| 10ml syringes |  | 20ml syringes |  | 60ml syringes |  | Giving Sets |  |
| 500ml Flexitainers |  | 1000ml Flexitainers |  | 130ml sterifeed bottle |  | 250ml sterifeed bottle |  |
| **Other Plastics/Ancillaries required (please specify description and quantities):** |
|  |
| **If requesting quantities in excess of BHFT Ancillary guidelines, please state reason for consideration:** |
|  |
| **ANY OTHER RELEVANT INFORMATION:** |
|  |

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