**Referral to Community Dietitians**

**Please return the completed form to the Referral Hub by email to**

**Bks-tr.healthhub@nhs.net**

**Referrals can also be made via the Hub by Phone 0300 365 1234 or Fax 0300 365 0400**

**Please complete ALL sections marked \* and any other relevant sections**

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| **\*NHS Number (1 digit per box please)**

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 | **Date of referral**  | **Patient Consented?**YES NO  |
| **\*Patient Name** **\*Patient Address****\*Patient Contact No**Home:Mobile: | **\*Referrer Name & Job Title****\*Referrer Address for correspondence****\*Referrer Contact No** |
| **Date of Birth** | **\*Ethnicity**  |
| **\*GP Name and Surgery** | **\*Reason for Referral** – complete any relevant info below that may be required for triage purposes |
| **Relevant Medical Condition** incl any allergies | **Relevant Medication**  |
| **Weight and height** if relevant to referral e.g. weight management., nutrition support | **BMI** Please provide BMI **or** weight and height if relevant to referral e.g. weight management programme, nutrition support advice. |
| **Blood test results** Are there any blood test results relevant to the referral e.g. Lipids, IGT, blood sugars? Please state results here. |
| **Nutrition Support – please supply**Must Score (must be 2+ to be accepted by the department for advice) …………………….  If unable to weigh please supply a MUAC (cm) …………………….Is patient on oral nutritional supplements? YES NO  Please tick relevant box**If Yes please list** …………………………………….. |
| **Dementia** Please tick relevant boxDoes this patient have dementia? YES NO  |
| **End of Life** Please tick relevant boxIs this patient receiving End of Life Care? YES NO   |
| **Does the patient require a home visit** Please tick relevant box YES NO  |