**Community Dietetics Referral Form**

**This form can only be completed by a healthcare professional. If you are a parent/carer please contact the child’s GP to make the referral on your behalf.**

**Please complete ALL sections of the form**

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

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 | **Date of referral**  |
| **Patient name:** **Patient address:****Patient contact number:**Home:Mobile: | **Referrer name and job title:****Referrer address for correspondence:****Referrer contact number:** |
| **Date of Birth:** | **Ethnicity:** |
| **GP name and surgery name:** | **Reason for Referral:** |
| **Relevant medical conditions incl any allergies** | **Any relevant medication:** |
| **Weight** | **Height** | **BMI** |
| **Blood test results**Are there any blood test results relevant to the referral eg Lipids, IGT, blood sugars?  |
| **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) ……………………. |
| **Alternative contact for patient** – please supply for Care Home, Ward and Nutritional Support Patients**Name: Contact Number:****Relationship to Patient:** |

**Please send the completed form to the Berkshire Integrated hub on**

**integratedhub@berkshire.nhs.uk** **or Fax to 0300 3650400**